APPROPRIATENESS OF CARE

"Better Care, Made Easier"

Patient First

2017 Canadian Association of Home Care Summits
Halifax Nova Scotia
November 15, 2017

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Improving Appropriateness of Care

Information I hope to leave with you today:

- An understanding of Appropriateness of Care:
  - What?
  - Why?
  - How?
- Ideas for applying the AC Framework to Home Care

Key Messages

- The Saskatchewan Healthcare System is striving to improve the Appropriateness of Care and have developed a Framework.

- Improving Appropriateness of Care (AC) may be considered to be ***Clinical Quality Improvement,*** which resonates with clinicians.

- Improving the quality of care and reducing health care costs can be achieved by addressing underuse, overuse and misuse of health care services.

- Targeting and reducing inappropriate care has not been a significant focus in quality improvement until recently- now gaining momentum across the country.

Questions for Home Care Colleagues

Key questions for Home Care organizations and providers of care:

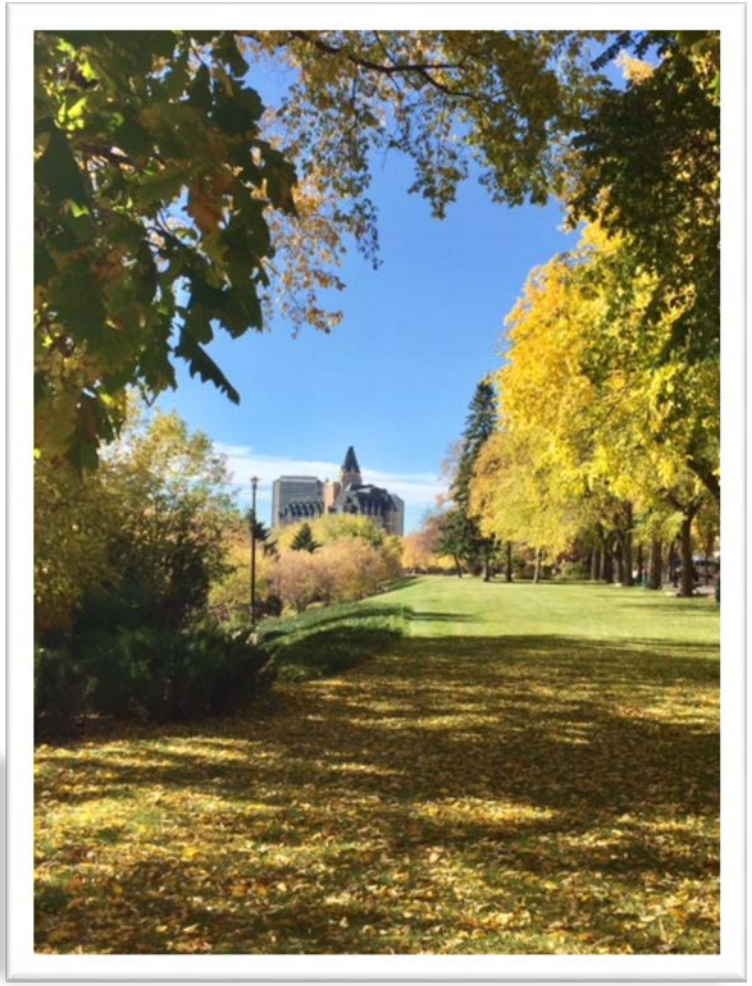
- Is every client assessed by HC “appropriate”?
- Do assessments meet the needs of the clients?
- Is there consistency of care, and care giver?
- Does every client receive appropriate services?
- Overuse? Underuse? Misuse? Variation in aspects of HC?

Land of Living Sky - Saskatchewan

Senior population in SK: 170,430 (15.5%)

251,366 square miles

Land of Living Sky - Saskatchewan



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Land of Living Sky - Saskatchewan

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Tommy Douglas
A Compelling Vision

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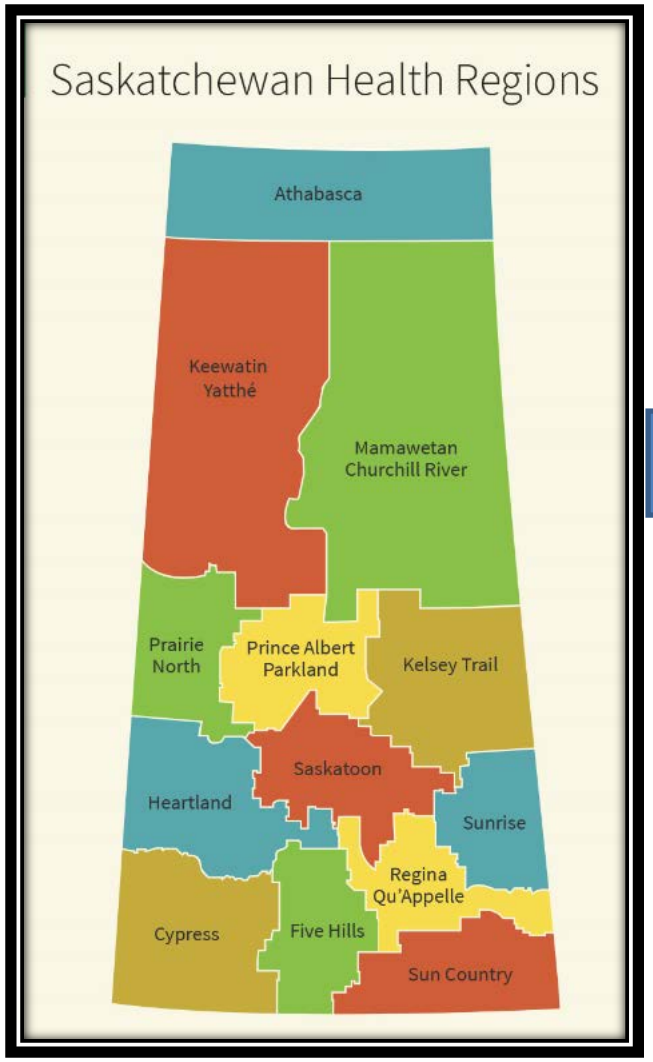
Saskatchewan Health Care System Current State
"Think and Act as One"

- 12 Regional Health Authorities
- 1 Provincially and Federally funded Health Authority
- Provincial Cancer Agency
- eHealth organization
- Shared Services Organization (3S Health)
- Health Quality Council
- 65 hospitals
- 156 long term care facilities
- Public Health Primary Health Care
- 43,104 Home Care clients in 2015-16
- First Nations & Inuit health services

Saskatchewan Health System
Future State



Transition to

A Single Health Region

Saskatchewan Health Authority

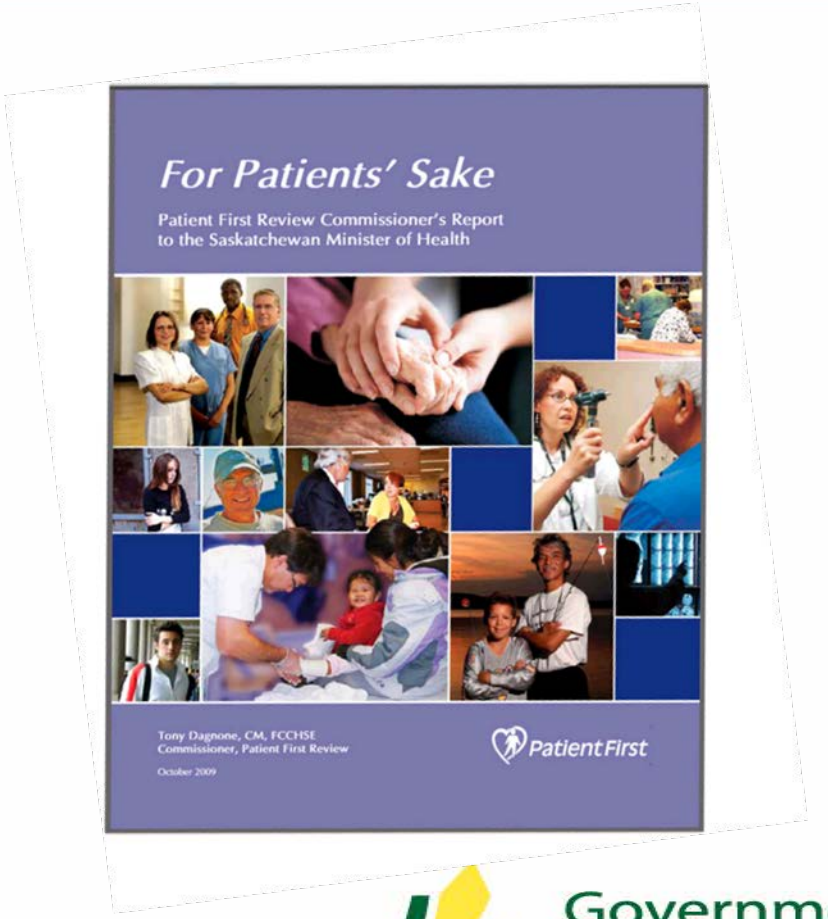
December 4, 2017

Government of Saskatchewan

The Patient's Perspective

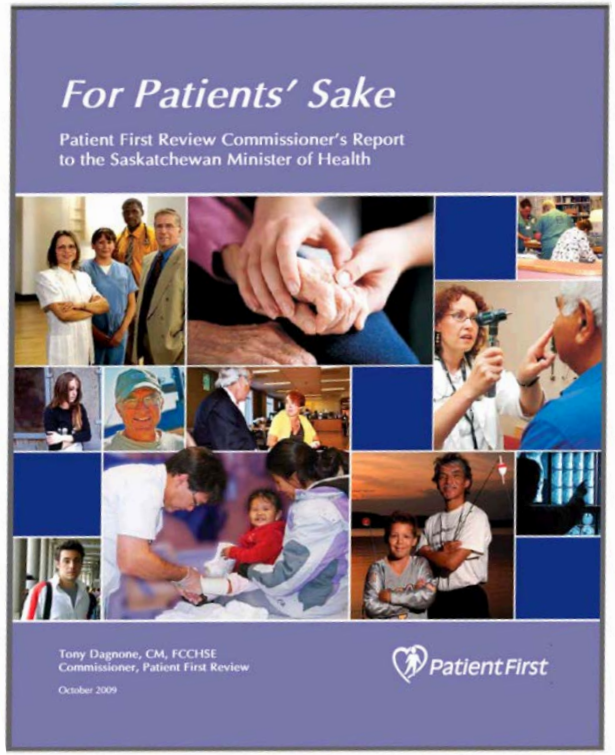
A Compelling Vision
Patient First Review 2009

- ***"Patient First"*** must be embedded as a core value in health care.
- Health care in Saskatchewan needs to function as a cohesive system.
- ***"Keep the Best, Fix the rest"***
- ***"Fix" = Eliminate waste: waste*** *is anything that does not add value in the eyes of the patient.*



A Compelling Vision
Patient First Review 2009

- Set provincial health strategy collaboratively
  - ➢ Identify a common vision
  - ➢ Set short- and long-term goals
  - ➢ Execute plans to achieve those goals
  - ➢ Track progress toward them
  - ➢ Change course as required
- Implementation of the SK Healthcare Management System



Why Now?

*The **Patient First Review** told us that Saskatchewan Residents clearly want assurance that their tax dollar is put to best use in ensuring high quality, safe care*

- Changing demographics : Growing and aging population
- Demands on the system continue to increase
- Increasing procedures, treatments, medications
- Increasing development and application of technology
- Increasing health care costs
- Current national and international focus on Appropriateness
- Province wide strategic planning
- Lean implementation underway
- Clinicians strongly support “Putting Patients First”
- Appropriateness improves clinical care: physician’s prime interest
- Choosing Wisely Canada

Why Now?

November 7th Media Headlines

“Health costs to total $242B in Canada; Saskatchewan fifth in per capita spending in 2017”

- *CIHI forecasts that $242 billion will be spent on health in Canada this year - a record high and more than $9 billion above the amount spent in 2016. This is the equivalent of $6,604 for every Canadian.*

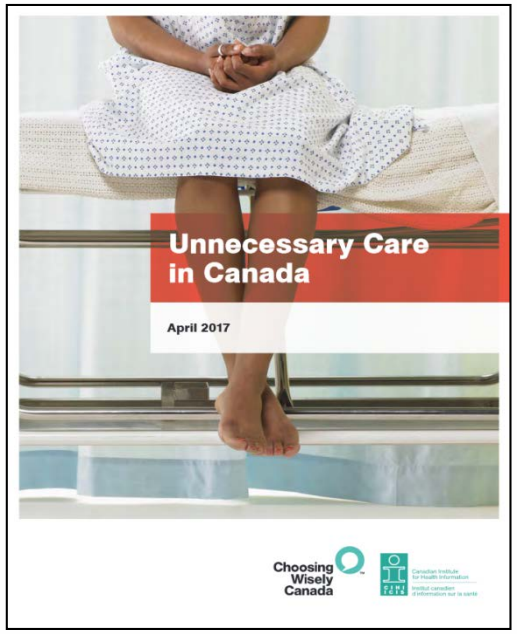
- *According to the CIHI report, health costs have been increasing because of population growth, population aging, inflation and changes in technologies and services.*

- *November 8th* ***Globe and Mail’s Andre Picard:*** *“It’s time for a data-driven approach to health care”*

Why Now?

"For many years, both physicians and patients have had a '**more is better**' **attitude**. It is time to adopt a **'think twice' attitude** to avoid unnecessary and potentially harmful tests, procedures and treatments."

Dr. Wendy Levinson, Chair, Choosing Wisely Canada
Chair, Department of Medicine, University of Toronto



Report available at: https://www.cihi.ca/en/unnecessary-care-in-canada

Saskatchewan Health Care System Vision

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Better Care | Better Health | Better Teams | Better Value

Saskatchewan Health System Multi-year Strategic Plan (2017-2021)

PROVINCIAL HOSHIN

To improve access for patients and reduce Emergency Department waits by 60%, necessary improvements in key areas (primary health care, specialist consults, diagnostics, mental health & addictions, long term care, home care, and acute care) will be achieved by 2019.

2017-18 System Priority Target: Reduce Emergency Department Waits by 35% by March 31, 2018.

Cross - Functional Hoshin Targets

Avoidable Admissions: By March 31, 2018, reduce unnecessary admissions for ambulatory care sensitive conditions presenting in Regina and Saskatoon hospitals by 5%.

Unnecessary Visits: By March 31, 2018, reduce the number of unnecessary Emergency Department visits in Regina and Saskatoon hospitals by 5%.

Re-Visit Rate: By March 31, 2018, reduce the 7-day re-visit rate to Emergency Departments in Regina and Saskatoon hospitals by 5%.

Readmission Rate: By March 31, 2018, reduce the 30-day readmission rate to hospitals in Regina and Saskatoon by 5%.

Patient Safety: By March 31, 2018, ≥ 95% of care transitions where clients are at risk of medication errors will have medication reconciliation performed.

2017-21 Outcomes

IMPROVED COMMUNITY SERVICES: A PATIENT-FIRST, PATIENT FLOW STRATEGY

Full Implementation of the Accountable Care System by March 31, 2021.

Accountable Hospital Care

Accountable Community Care

MODERNIZING THE HEALTH SYSTEM

The most effective and efficient health care structure for Saskatchewan that supports improved patient care.

CULTURE OF SAFETY:

To achieve a culture of safety, by March 31, 2020, there will be no harm to patients or staff.

Outcome Targets

Primary Health Care: By March 31, 2020, 50% of patients living with one or more of four common chronic conditions (Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, and Heart Failure) are receiving best practice care as evidenced by completion of provincial templates available through approved electronic medical records and the Electronic Health Record viewer.

- In-year target for 2017-18: 30% of patients receiving this care.

By March 31, 2018, people living with chronic conditions will experience better health as indicated by a 10% decrease in hospital utilization related to six common chronic conditions (Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Heart Failure, Depression, and Asthma).

Mental Health & Addictions: By March 31, 2018, progress made across ministries on the recommendations in the *Mental Health and Addictions Action Plan*.

By March 31, 2018, complete the evaluation based on the phase one roll out of the LOCUS (Level of Care Utilization System) tool and provincial electronic record and establish a plan for further roll out.

By March 31, 2018, there will be a 25% increase in the number of individuals who receive internet-based cognitive behavioral therapy.

By March 31, 2018, Take Home Naloxone Kits will be available in all regional health authorities.

Specialists & Diagnostics: By March 31, 2018, implement the Provincial Referral Model with two new specialty groups reducing patient wait times by 25% within 12 months of the start date.

By March 31, 2018, patient satisfaction with the referral process within two new specialty groups will increase by 25% within 12 months of the start date.

By March 31, 2018, expand the LINK Telephone Consult Service to include three additional specialties.

Seniors: By March 31, 2020, a 10% reduction in the number of days spent in hospital during the last 6 months of life among seniors as an indicator of improved access to community-based services.

By March 31, 2018, 100% of Saskatchewan long-term care facilities will meet the benchmark targets established for the seven quality indicators related to physical restraints, antipsychotics without a diagnosis, pain worsened, pressure ulcer newly occurring, pressure ulcer worsened, bladder continence worsening, and falls.

By March 31, 2018, Purposeful Rounding will be implemented in 100% of long-term care facilities.

Appropriateness: By March 31, 2018, 80% of clinicians in at least three selected clinical areas will be utilizing agreed upon best practices.

By March 31, 2018, each RHA will complete implementation of at least two clinical quality improvement projects.

By March 31, 2018, each RHA will have at least one physician participating in clinical quality improvement training.

By March 31, 2018, there will be 80% compliance with the CT Lumbar Spine Checklist in four selected health regions that implemented the checklist (Regina Qu'Appelle, Saskatoon, Five Hills and Prairie North).

By March 31, 2018, there will be 80% compliance with the agreed upon pre-operative evaluation guidelines in the four selected health regions that implemented the guidelines (Regina Qu'Appelle, Saskatoon, PA Parkland and Prairie North).

Health System Restructure: By fall 2017, a Provincial Health Authority is enacted and operating.

Physician Collaboration: By March 31, 2018, one demonstration site will be established with active physician leadership in the planning, management, governance and resource management of health services to a population or geographic area, based on successful approaches from high performing systems.

Safety Alert / Stop the Line: By March 31, 2018, Safety Alert / Stop the Line will be implemented in 100% of acute care facilities in Saskatchewan.

Workplace Safety: By March 31, 2018, the health care system in Saskatchewan will investigate 100% of time-loss injuries involving shoulder and back to root cause.

By March 31, 2018, the health care system in Saskatchewan will fully implement the Safety Management System.

Last update: March 31/17

Appropriateness of Care 2017-18 Targets

- By March 31, 2018, 80% of clinicians in 3 selected clinical areas will be utilizing agreed upon best practices.
- By March 31, 2018, each RHA will complete implementation of at least two clinical quality improvement projects.
- By March 31, 2018, each RHA will have at least one physician participating in clinical quality improvement training.
- By March 31, 2018, there will be 80% compliance with the CT Lumbar Spine Checklist in four selected health regions.
- By March 31, 2018, there will be 80% compliance with the agreed upon pre-operative evaluation guidelines in four selected health regions.

Appropriateness of Care

"The right care, provided by the right providers, to the right patient, in the right place, at the right time, resulting in optimal quality care."

Canadian Medical Association 2013

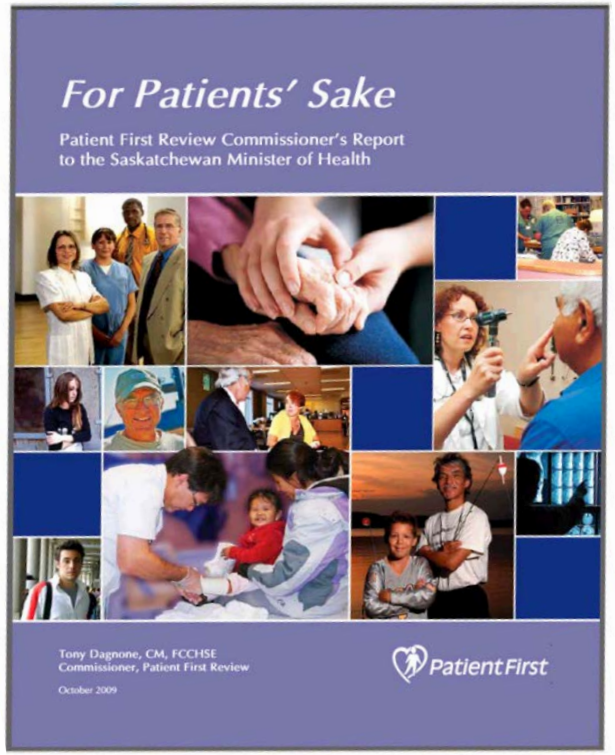
OVERUSE, UNDERUSE, MISUSE AND VARIATION

- Patients may receive services that are unnecessary (overtreatment, unnecessary tests), increase costs, and may even endanger their health: ***Overuse of services.***

- Patients may not receive care that they should have received but was missed and, as a result, may suffer complications that add to costs: ***Underuse of services.***

- Patients may receive wrong services/care during the course of their treatment, and some die prematurely as a result: ***Misuse of services.***

- Patients with the same health issues will often receive very different care, depending on where they live: ***Variation in services.***



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The Journey

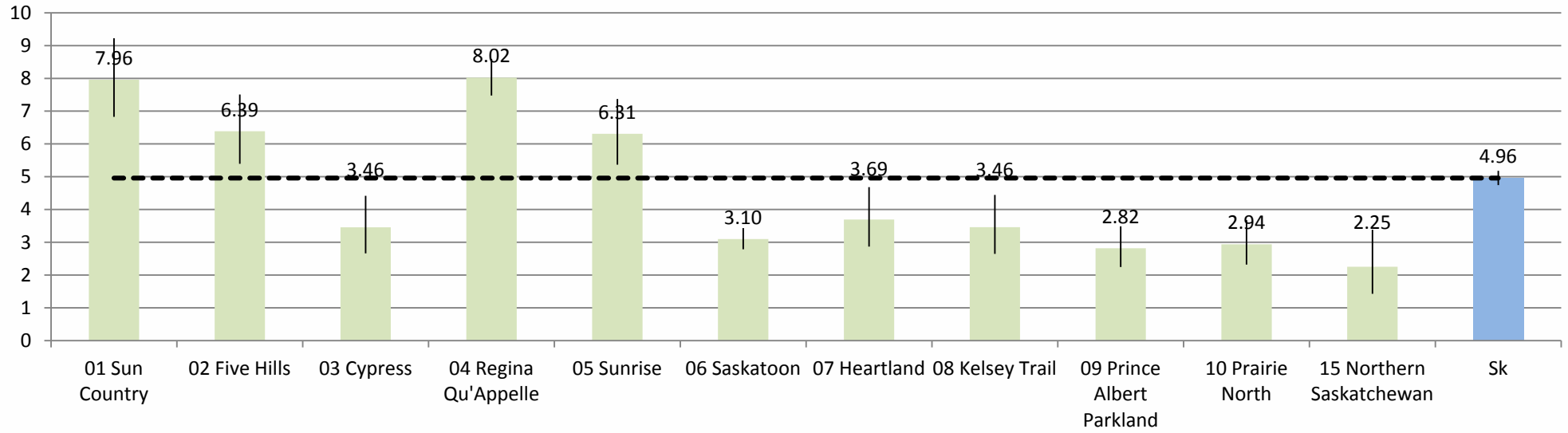
- Saskatchewan Surgical Initiative 2010-2014
  - ❖ Surgical variation

- AC identified as a provincial strategic priority in 2015-16:
  - ➢ By March 31, 2018, 80% of clinicians in 3 selected clinical areas will be utilizing agreed upon best practices.

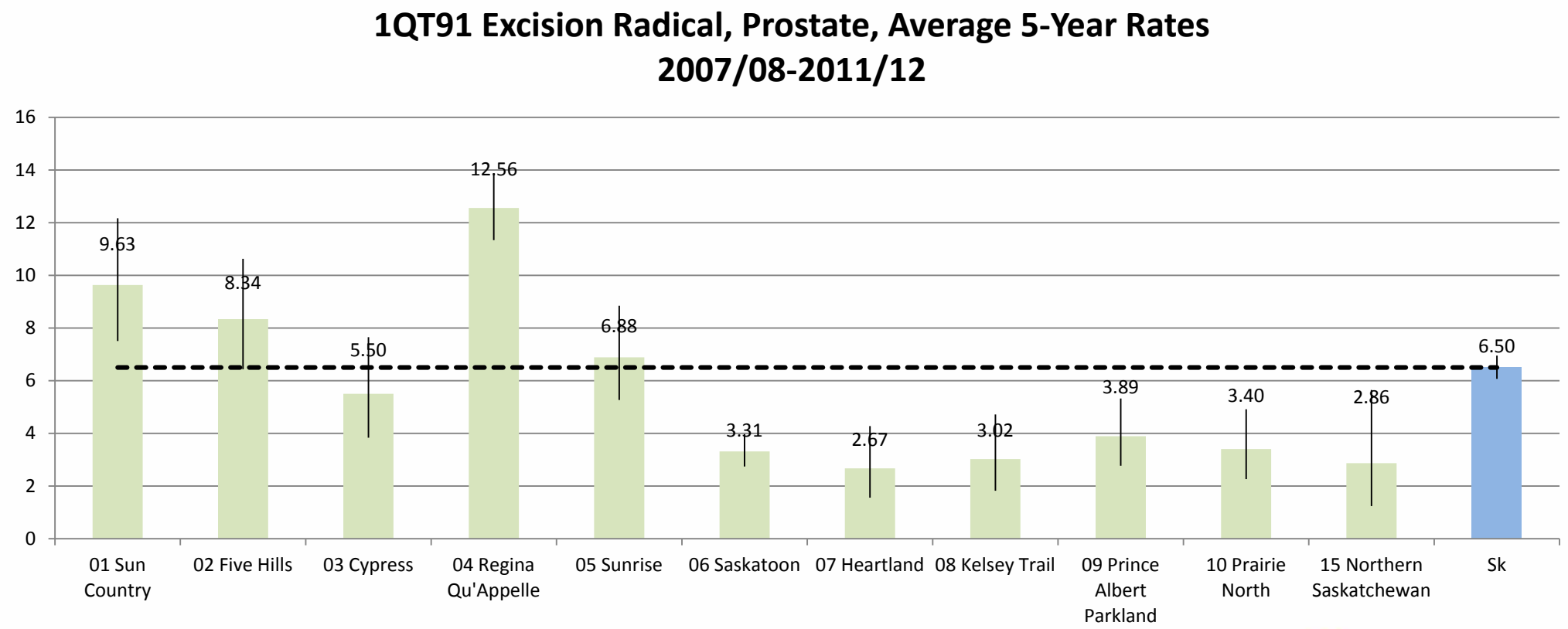
- Provincial AC Framework developed and tested 2015-16

Lower Spine Surgery- Spinal Fusions

1SC75 Fusion, Spinal Vertebrae, Average 5-Year Rates
2007/08-2011/12



Urology- Radical Prostatectomy



Improving Appropriateness of Care

The Journey

- Who are we?

  - Provincial AC Program Team established 2015
  - Physician Leaders: 2 surgeons, SK Senior Medical Officer
  - Supported by HQC and Ministry of Health
  - Report directly to the Ministry of Health

- Provincial AC Network

The Framework

- Principles developed by SK Senior Leaders and physicians
- Developed during several visioning sessions with key SK leaders and physicians
- Lessons learned from high performing health care organizations- focus on Intermountain Health in Salt Lake City Utah

The Framework

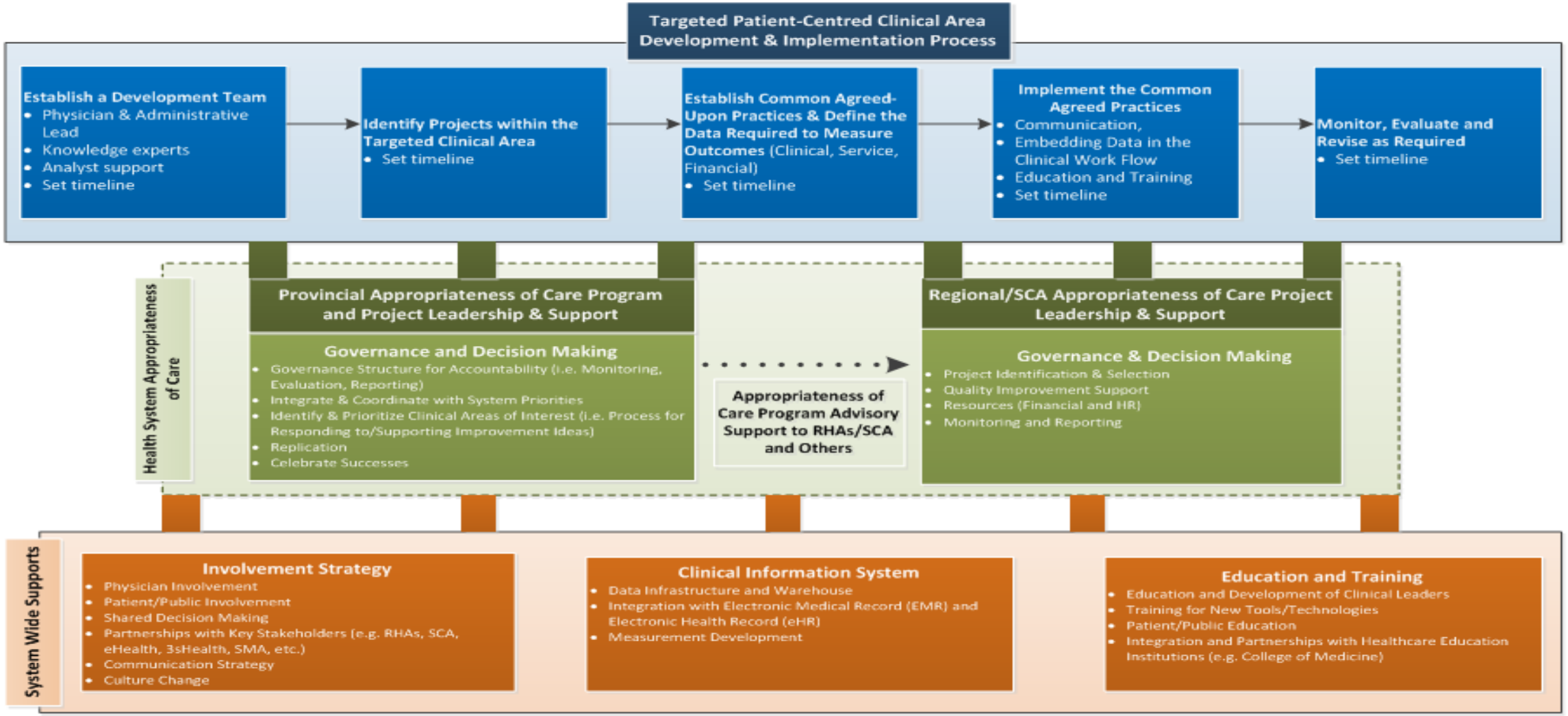
- Purpose
  - to provide a shared understanding of what AC means to patients, clinicians, health system stakeholders and the public, as well as a shared vision for improving AC in Saskatchewan.

- Components:
  - a quality improvement methodology to improve Appropriateness of Care at the clinical practice level and the required system structures to embed Appropriateness of Care into Saskatchewan health care organizations;
  - a stakeholder engagement and communication plan;
  - a plan that outlines infrastructure requirements for capturing, analyzing and reporting essential data; and
  - a toolkit with information to support groups or organizations who want to undertake improvement work in any clinical area.

Appropriateness of Care Framework

Better Care, Made Easier

Vision: "*The Right Care, provided by the Right Providers, to the Right Patient, in the Right Place, at the Right Time, resulting in Optimal Quality Care (CMA Definition).*"
Outcome Target: By March 31, 2018, 80% of clinicians in 3 selected clinical areas within two or more service lines will be utilizing agreed upon best practices.
Improvement Target: *By March 31, 2016, at least one clinical area within a service line will have deployed care standards and will be actively using measurement and feedback to inform improvement.*



Physician Involvement Strategy

- Increase physician knowledge, involvement and leadership in AC work
- Collaboration with physician organizations (i.e. SMA)
- Alignment with Choosing Wisely Canada
- Providing physicians with opportunities to improve clinical QI knowledge and skills

Clinical Quality Improvement Program (CQIP)

- Adapted from Intermountain Health in Utah
- Designed to increase physicians' knowledge and skills for leading clinical QI projects
- CME accredited
- 16 physicians enrolled as the 1st cohort in January 2017
- Each participant is required to lead a clinical QI project
- Remuneration provided to participants, faculty members and physician coaches
- 2nd cohort underway in January 2018: 37 applicants!

CQIP Cohort #1 Clinical QI Projects

- Sepsis: Does Early Warning Score Influence Care?
- Optimizing Use of Single Fraction Palliative Radiation Therapy for Bone Metastases
- Reducing Unnecessary Preoperative Tests
- Embracing Handshake Stewardship: Utility of Collaborative, Prospective Audit and Feedback Rounds in an Intensive Care Unit
- Reducing the Use of Ultrasound in the Diagnosis of Clinically Evident Inguinal Hernias
- Venous Thromboembolism Prophylaxis in Post-Operative Abdominal/Pelvic Cancer Patients: Are We Meeting the Mark?
- Multidisciplinary Progress Notes and Standardization of Inpatient Charts
- The Truth about Discharge Summaries: Acute Tertiary Medicine to Community
- Transition to Ultrasound Follow-up of Endovascular Abdominal Aortic Repair
- From Waitlisting to Early Treatments for Kids: An Improvement Journey through Collaborative Care & Pooled Referral Processes in Pediatric Psychiatry
- The Development of a Breast Pathology Subspecialty Model – Saskatoon Experience
- Improving the Management of COPD Exacerbations in a Regional Health Centre ER
- Reduction of Respiratory Swabs and Chest X-ray by 50% in the Management of Acute Bronchiolitis in Children
- Shared Care for Improved Care: Reducing Time to Psychiatric Consultation Using a Shared Care Model
- Increasing Offers of HIV Tests in rural SK

SMA's Appropriateness of Care Initiative (SACI)

- An informal program designed to help physicians who have a QI idea develop their idea into a clinical QI project
- Use a centralized intake process to provide support:
  - Coaching by a physician who has QI experience and knowledge
  - Project development advice
  - Data/measurement support
- SACI pilot: fall 2017.

Health System and Patient Involvement Strategy

- Collaboration with system stakeholders (RHAs, HQC, eHealth, SCPOR)
- Patient/public involvement strategy focuses on:
  - Involvement of patient and family advisors (PFAs) in the AC governance structure and AC projects
  - Embedding Shared Decision Making in AC work
  - Linking with Choosing Wisely Saskatchewan's public awareness strategy

Efforts to Build System Capacity

- Initiated 4 provincial AC projects:
  - Lumbar spine MRI & CT Checklists
  - Pre-op testing and evaluation
  - Improving quality of colonoscopy
- Funding provided to increase data analytic/measurement capacity
- Physicians involved in AC are compensated
- AC webpage developed
- AC Inventory started- replication encouraged

Choosing Wisely

A national 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.

Choosing Wisely Saskatchewan is a proud partner of ***Choosing Wisely Canada***

Choosing Wisely Saskatchewan™

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Choosing Wisely Canada™

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

ASSOCIATION MÉDICALE CANADIENNE | CANADIAN MEDICAL ASSOCIATION

Forum on General Family and Practice Issues

Eleven Things Physicians and Patients Should Question

1 Don't do imaging for lower-back pain unless red flags are present.

Red flags include, but are not limited to, severe or progressive neurological deficits or when serious underlying conditions such as osteomyelitis are suspected. Imaging of the lower spine before six weeks does not improve outcomes.

2 Don't use antibiotics for upper respiratory infections that are likely viral in origin, such as influenza-like illness, or self-limiting, such as sinus infections of less than seven days of duration.

Bacterial infections of the respiratory tract, when they do occur, are generally a secondary problem caused by complications from viral infections such as influenza. While it is often difficult to distinguish bacterial from viral sinusitis, nearly all cases are viral. Though cases of bacterial sinusitis can benefit from antibiotics, evidence of such cases does not typically surface until after at least seven days of illness. Not only are antibiotics rarely indicated for upper respiratory illnesses, but some [illegible] experience adverse effects from such medications.

3 Don't order screening chest X-rays and ECGs for a[illegible] risk outpatients.

There is little evidence that detection of coronary artery stenosis [illegible] disease improves health outcomes. False positive tests [illegible] over-treatment and misdiagnosis. Chest X-rays [illegible] trivial diagnostic yield, but a significant number [illegible] potential benefit.

4 Don't screen women with Pap [illegible] years of age.

- Don't do screening Pap smears annually in wo[illegible]
- Don't do Pap smears in women who have had a [illegible]

The potential harm from screening women younger th[illegible] to suggest the necessity of conducting this test annua[illegible] hysterectomy for benign disorders no longer require th[illegible] results were normal.

5 Don't do annual screening blood t[illegible] risk profile of the patient.

There is little evidence to indicate there is value in routine b[illegible] likely to produce false positive results that may lead to add[illegible] tests, and the selection of which tests to perform, should be[illegible] possible risk factors.

6 Don't routinely measure Vitamin D in[illegible] risk adults.

Because Canada is located above the 35° North latitude, the average Canadian's exposure to sunlight is insufficient to maintain adequate Vitamin D levels, especially during the winter. Therefore, measuring serum 25-hydroxyvitamin D levels is not necessary because routine supplementation with Vitamin D is appropriate for the general population. An exception is made for measuring Vitamin D levels in patients with significant renal or metabolic disease.

There are now over 230 Canadian Choosing Wisely Recommendations

Sources

1 Canadian Association of Radiologists. The 2012 CAR diagnostic imaging referral guidelines [Internet]. 2012 [cited 2014 Feb 15]. Available from: http://www.car.ca/uploads/standards%20guidelines/car-referralguidelines-c-en_20120918.pdf.

Chou R, Fu R, Carrino JA, Deyo RA. Imaging strategies for low-back pain: Systematic review and meta-analysis. Lancet. 2009 Feb 7;373(9662):463-72.

Ontario Ministry of Health and Long Term Care (MOHLTC). Excellent care for all - low back pain strategy [Internet]. 2013 [cited 2014 Feb 15]. Available from: http://www.health.gov.on.ca/en/pro/programs/ecfa/action/primary/lb_adultools.aspx.

Physicians of Ontario Collaborating for Knowledge Exchange and Transfer (POCKET). Red and yellow flag indicator cards [Internet]. 2005 [cited 2014 Feb 15]. Available from: http://www.iwh.on.ca/physicians-network-tool-kit.

Williams CM, Maher CG, Hancock MJ, McAuley JH, McLachlan AJ, Britt H, et al. Low back pain and best practice care: A survey of general practice physicians. Arch Intern Med. 2010 Feb 8;170(3):271-7.

2 American Academy of Allergy Asthma and Immunology. Sinus infections account for more antibiotic prescriptions than any other diagnosis [Internet]. 2013 [cited 2014 Feb 15]. Available from: http://www.aaaai.org/global/latest-research-summaries/Current-JACI-Research/sinus-infection-antibiotic.aspx.

Desrosiers M, Evans GA, Keith PK, Wright ED, Kaplan A, Bouchard J, et al. Canadian clinical practice guidelines for acute and chronic rhinosinusitis. Allergy Asthma Clin Immunol. 2011 Feb 10;7(1):2.1492-7-2.

Hirschmann JV. Antibiotics for common respiratory tract [illegible]ections in adults. Arch Intern Med. 2002 Feb 11;162(3):256-64.

Low D. Reducing antibiotic use in influenza: Ch[illegible] rewards. Clin Microbiol Infect. 2008 Apr;14(4):298-306.

Meltzer EO, Hamilos DL. Rhinosi[illegible] gement for the clinician: A synopsis of recent consensus guidelines. Mayo Clin Proc. 2011 May;86(5):427-43.

Schumann [illegible] ilitis? Here is a good reason to say "no". J Fam Pract. 2008 Jul;57(7):464-8.

[illegible] moderate sinusitis. Arch Intern Med. 2012 Mar 26;172(6):510-3.

[illegible]ging referral guidelines. Section E: cardiovascular [Internet]. 2012 [cited 2014 Feb 15]. Available [illegible]rralguidelinee-e-en-20121011.pdf.

[illegible]n a focus on x ray usage and safety [Internet]. [Cited 2014 Feb 15]. Available from: [illegible]guide_radiation_primer_rev20151124.pdf.

[illegible]diography in a primary care setting. Radiology. 2004 Nov;233(2):575-8.

[illegible]y heart disease with electrocardiography [Internet]. 2012 Jul [cited 2014 Feb 15]. Available [illegible]dis/chdlinalrs.htm.

[illegible]lines: Environmental scan [Internet]. 2013 Sep [2014 Feb 15]. Available from: [illegible]vical_cancer_enviro_scan.pptx.

[illegible]ane A, Kerner J, Bryant H, et al. Recommendations on screening for cervical cancer.

[illegible]net]. 2010 [cited 2014 Feb 15]. Available from:

[illegible]g in the ambulatory general medical examination. Am J Med. 1996 Aug;101(2):142-

[illegible]ntive services: An assessment of the effectiveness of 169 interventions [Internet]. 1989 [cited 2014 [illegible]/prevguid/p0000109/p0000109.asp.

[illegible]ch, why, and what do the results mean?. Lab Med. 2009;40:105-13.

[illegible] Protocol Advisory Committee. Vitamin D testing protocol [Internet]. 2013 Jun 1 [cited 2014 Sep 25]. Available from: [illegible]/www.bcguidelines.ca/guideline_vitamind.html.

Hanley DA, Cranney A, Jones G, et al. Vitamin D in adult health and disease: a review and guideline statement from Osteoporosis Canada. CMAJ. Sep 7 2010;182(12):E610-618.

Ontario Association of Medical Laboratories. Guideline for the Appropriate Ordering of Serum Tests for 25-hydroxy Vitamin D and 1,25-dihydroxy Vitamin D [Internet]. 2010 Jun [cited 2014 Sep 25]. Available from: http://oaml.com/wp-content/uploads/2016/05/OAML-Vit-D-Guideline-Jn-162010-FINAL.pdf.

About The CMA's Forum on General and Family Practice Issues

The Canadian Medical Association's (CMA) Forum on General and Family Practice Issues (GP Forum) is a proud partner of the Choosing Wisely Canada campaign. The GP Forum is a group of family physician leaders in every province and one territory (NWT) in Canada. These individuals are members or chairs of that jurisdiction's Section of General Practice. It also includes representation from the following organizations: the College of Family Physicians of Canada, the Canadian Medical Protective Association, the Society of Rural Physicians of Canada, Canadian Forces Health Services, the Canadian Association of Internes and Residents, the Canadian Federation of Medical Students and one CMA Board member who is a family physician. The primary purpose of the GP Forum is to provide expertise and advice to the CMA on issues concerning primary health care. Note: The GP Forum was dissolved as of August 2015.

About The College of Family Physicians of Canada

The College of Family Physicians of Canada (CFPC) is a proud partner of the Choosing Wisely Canada campaign. The CFPC represents more than 30,000 members across the country. It is the professional organization responsible for establishing standards for the training, certification and lifelong education of family physicians. The College provides quality services and programs, supports family medicine teaching and research, and advocates on behalf of family physicians and the specialty of family medicine. The CFPC accredits postgraduate family medicine training in Canada's 17 medical schools.undergraduate and continuing medical education and encourages the development of research in oncologic surgery. The CSSO believes in facilitating communication between surgeons whose primary interest lies in the field of oncology and encourages the formation of surgical oncology training programs among Canadian Universities.

Role of SK Network

- Engage patients and public
- Support grassroots Choosing Wisely initiatives
- Support provincial priorities that align with Choosing Wisely
  - Pre-operative testing
  - Imaging of low back
- Share knowledge and best practices across Saskatchewan & Canada

SASKATCHEWAN HEALTH QUALITY COUNCIL

SMA SASKATCHEWAN MEDICAL ASSOCIATION

UNIVERSITY OF SASKATCHEWAN
College of Medicine
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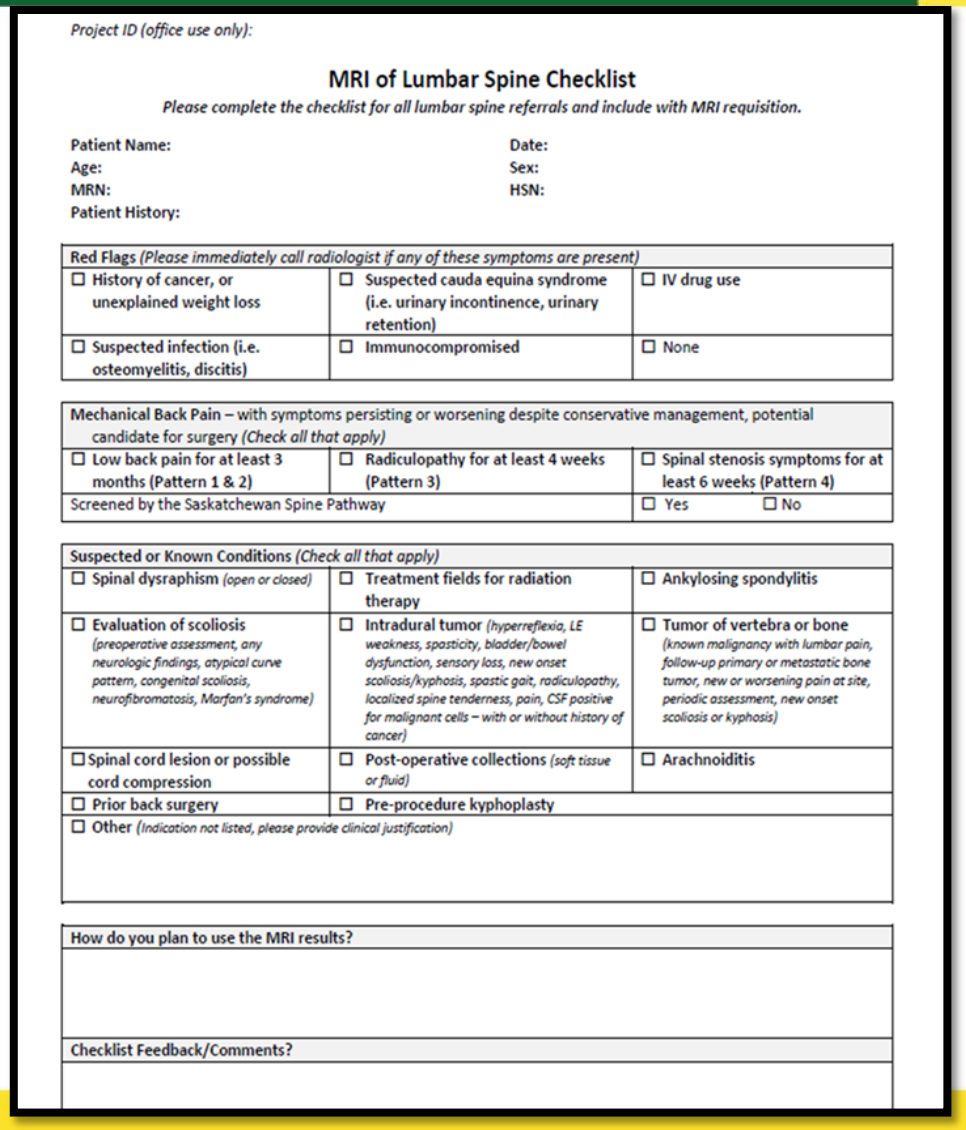
Lumbar Spine MRI Checklist

- MRI volumes in Canada have doubled in less than a decade
- About 5000 MRIs performed on lumbar spine in SK annually
- Over 50% of the MRI requests for lumbar spine were considered "*inappropriate*" or "*uncertain value*" (Emery et al January, 2013)
- **Unnecessary MRIs increase wait times for those patients who truly need an MRI**

Lumbar Spine MRI Checklist

- Project led by physicians and patient advisors:
  - **Goal**: improve appropriate ordering of MRI for adult outpatients with low back pain
- A checklist successfully trialed in RQHR and SHR in the fall of 2015 (above 90% physician compliance rate)
- Key challenge - privacy processes related to data collection and sharing



Project ID (office use only):

MRI of Lumbar Spine Checklist

Please complete the checklist for all lumbar spine referrals and include with MRI requisition.

Patient Name: **Date:**
Age: **Sex:**
MRN: **HSN:**
Patient History:

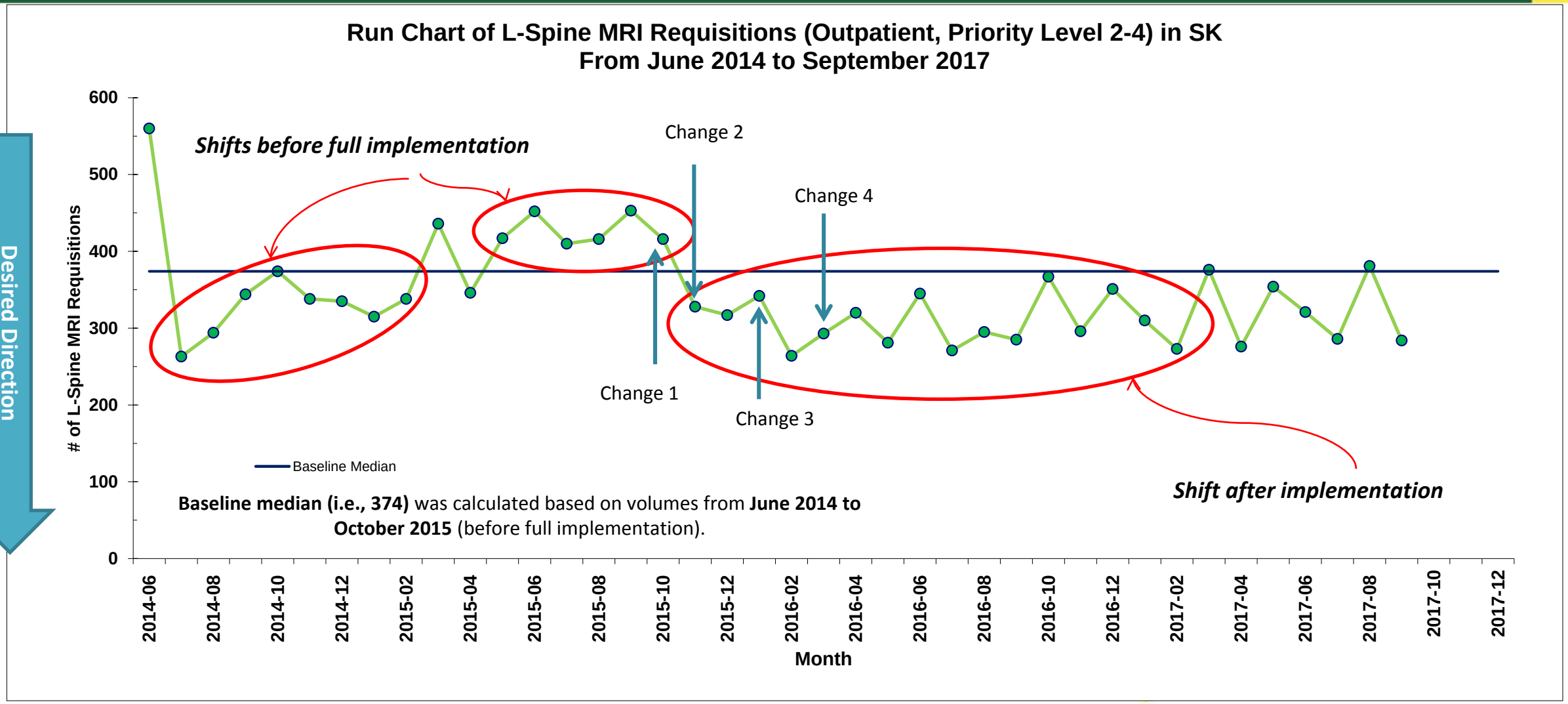
Red Flags *(Please immediately call radiologist if any of these symptoms are present)*		
☐ History of cancer, or unexplained weight loss	☐ Suspected cauda equina syndrome (i.e. urinary incontinence, urinary retention)	☐ IV drug use
☐ Suspected infection (i.e. osteomyelitis, discitis)	☐ Immunocompromised	☐ None

Mechanical Back Pain – with symptoms persisting or worsening despite conservative management, potential candidate for surgery *(Check all that apply)*		
☐ Low back pain for at least 3 months (Pattern 1 & 2)	☐ Radiculopathy for at least 4 weeks (Pattern 3)	☐ Spinal stenosis symptoms for at least 6 weeks (Pattern 4)
Screened by the Saskatchewan Spine Pathway		☐ Yes ☐ No

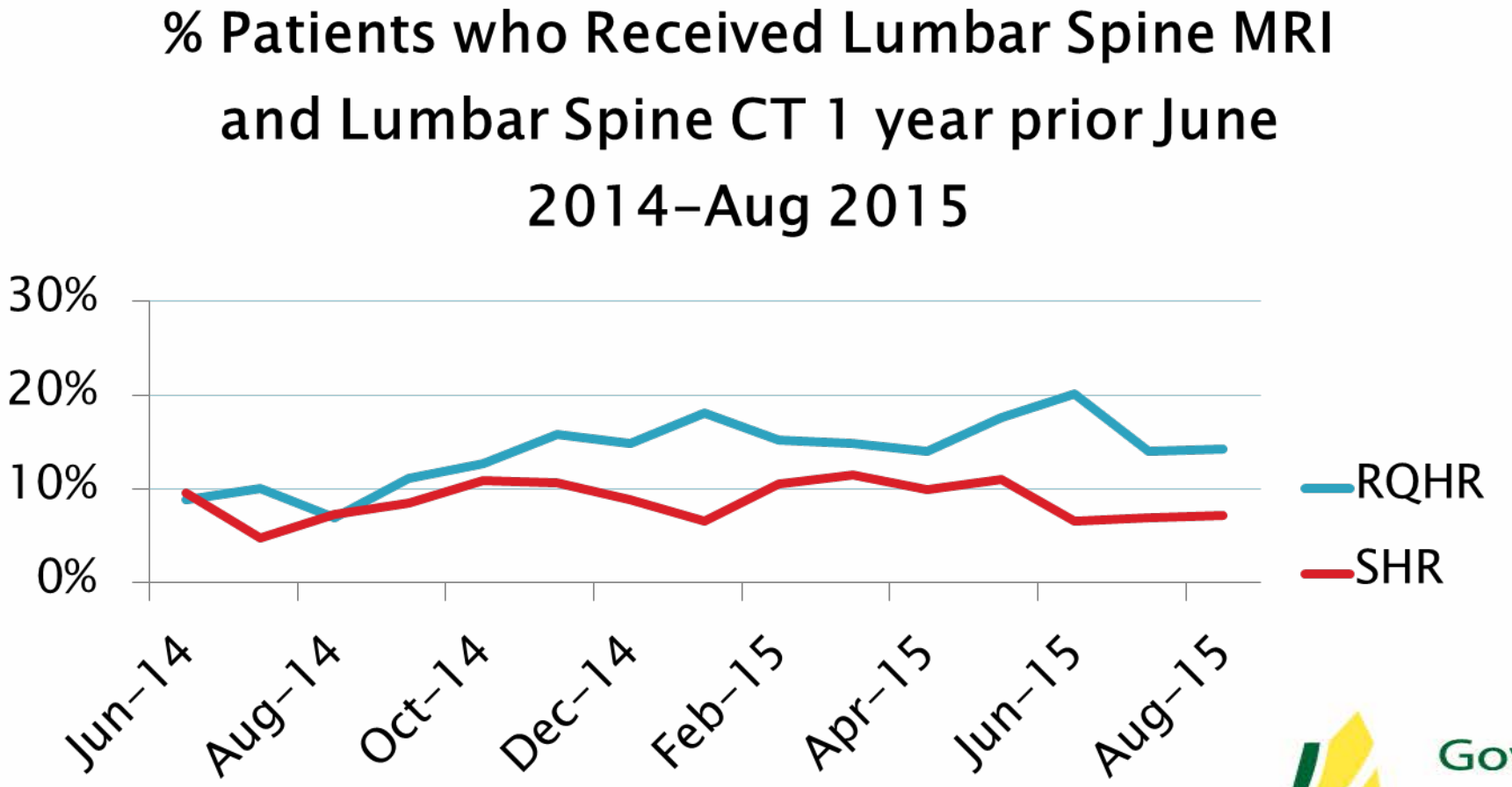
Suspected or Known Conditions *(Check all that apply)*		
☐ Spinal dysraphism *(open or closed)*	☐ Treatment fields for radiation therapy	☐ Ankylosing spondylitis
☐ Evaluation of scoliosis *(preoperative assessment, any neurologic findings, atypical curve pattern, congenital scoliosis, neurofibromatosis, Marfan's syndrome)*	☐ Intradural tumor *(hyperreflexia, LE weakness, spasticity, bladder/bowel dysfunction, sensory loss, new onset scoliosis/kyphosis, spastic gait, radiculopathy, localized spine tenderness, pain, CSF positive for malignant cells – with or without history of cancer)*	☐ Tumor of vertebra or bone *(known malignancy with lumbar pain, follow-up primary or metastatic bone tumor, new or worsening pain at site, periodic assessment, new onset scoliosis or kyphosis)*
☐ Spinal cord lesion or possible cord compression	☐ Post-operative collections *(soft tissue or fluid)*	☐ Arachnoiditis
☐ Prior back surgery	☐ Pre-procedure kyphoplasty	
☐ Other *(Indication not listed, please provide clinical justification)*		

How do you plan to use the MRI results?
Checklist Feedback/Comments?

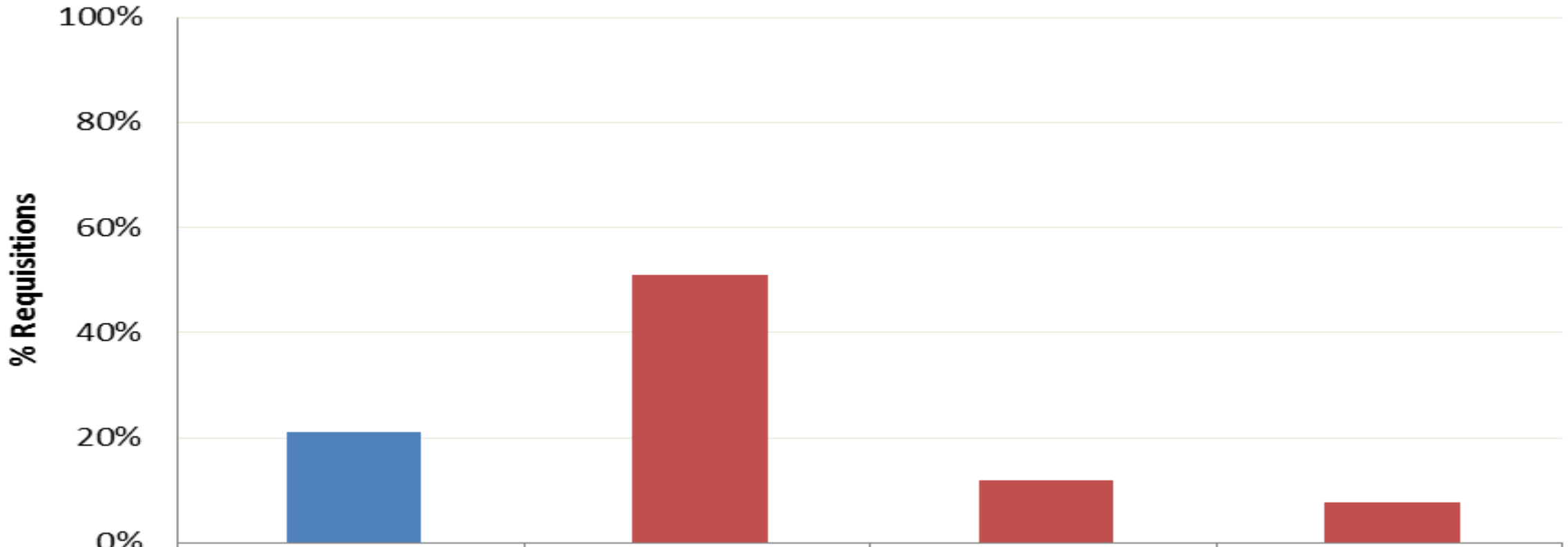
Volume of L-Spine MRI Requisitions in SK



Duplicate Imaging – CT and MRI



CT L Spine Requisitions, by Indication (all physician specialties)

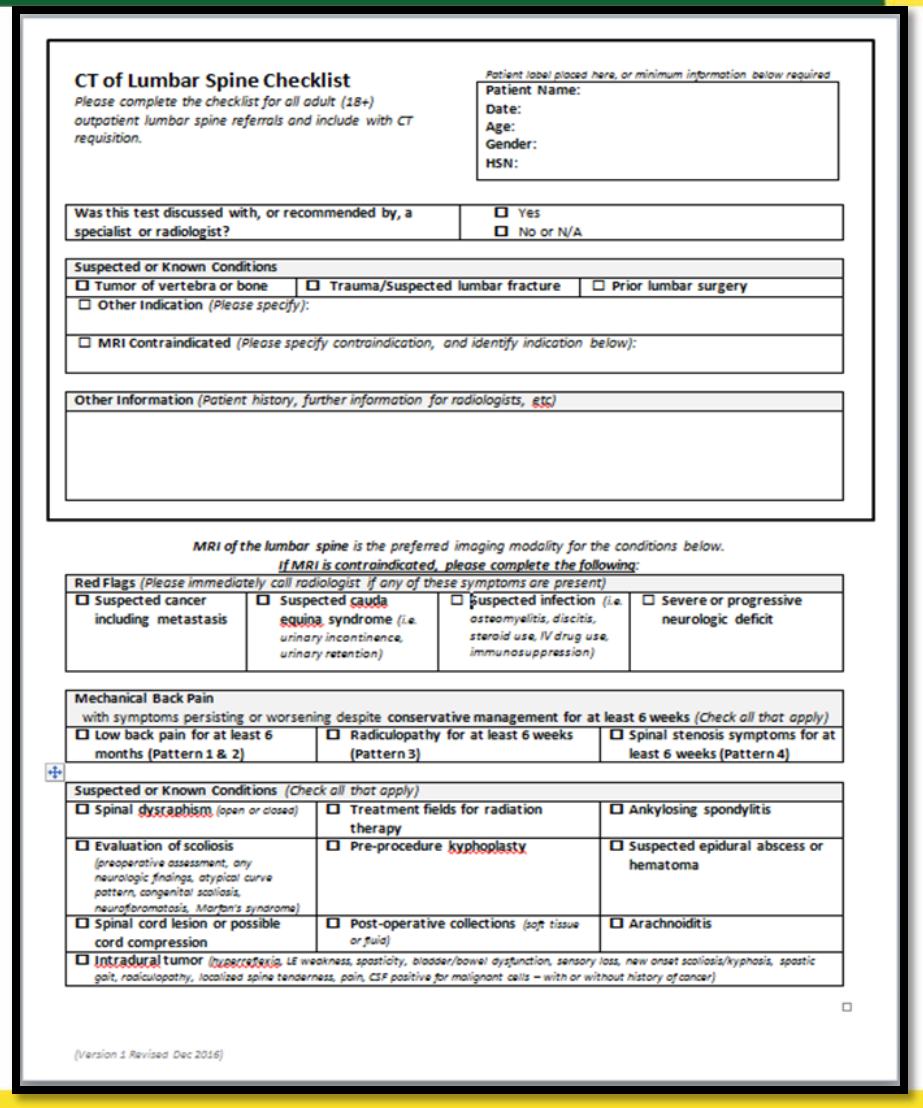


	Fall & Trauma	Low Back Pain	Leg Pain & Weakness	Sciatica
# reqs	58	140	33	21
% reqs	21%	51%	12%	8%

Lumbar Spine CT Checklist

- **CT is only appropriate for**:
  - ➢ Tumor of vertebra or bone
  - ➢ Trauma / suspected lumbar fracture
  - ➢ Prior lumbar surgery
  - ➢ MRI is contraindicated

- **Patient safety** is a concern for unnecessary CT sans.



CT of Lumbar Spine Checklist

Please complete the checklist for all adult (18+) outpatient lumbar spine referrals and include with CT requisition.

Patient label placed here, or minimum information below required

Patient Name:
Date:
Age:
Gender:
HSN:

Was this test discussed with, or recommended by, a specialist or radiologist?	☐ Yes ☐ No or N/A

Suspected or Known Conditions

☐ Tumor of vertebra or bone	☐ Trauma/Suspected lumbar fracture	☐ Prior lumbar surgery
☐ Other Indication *(Please specify)*:		
☐ MRI Contraindicated *(Please specify contraindication, and identify indication below)*:		

Other Information *(Patient history, further information for radiologists, etc)*

***MRI of the lumbar spine** is the preferred imaging modality for the conditions below.*
If MRI is contraindicated, please complete the following:

Red Flags *(Please immediately call radiologist if any of these symptoms are present)*

☐ Suspected cancer including metastasis	☐ Suspected cauda equina syndrome *(i.e. urinary incontinence, urinary retention)*	☐ Suspected infection *(i.e. osteomyelitis, discitis, steroid use, IV drug use, immunosuppression)*	☐ Severe or progressive neurologic deficit

Mechanical Back Pain
with symptoms persisting or worsening despite **conservative management for at least 6 weeks** *(Check all that apply)*

☐ Low back pain for at least 6 months (Pattern 1 & 2)	☐ Radiculopathy for at least 6 weeks (Pattern 3)	☐ Spinal stenosis symptoms for at least 6 weeks (Pattern 4)

Suspected or Known Conditions *(Check all that apply)*

☐ Spinal dysraphism *(open or closed)*	☐ Treatment fields for radiation therapy	☐ Ankylosing spondylitis
☐ Evaluation of scoliosis *(preoperative assessment, any neurologic findings, atypical curve pattern, congenital scoliosis, neurofibromatosis, Marfan's syndrome)*	☐ Pre-procedure kyphoplasty	☐ Suspected epidural abscess or hematoma
☐ Spinal cord lesion or possible cord compression	☐ Post-operative collections *(soft tissue or fluid)*	☐ Arachnoiditis
☐ Intradural tumor *(hyperreflexia, LE weakness, spasticity, bladder/bowel dysfunction, sensory loss, new onset scoliosis/kyphosis, spastic gait, radiculopathy, localized spine tenderness, pain, CSF positive for malignant cells – with or without history of cancer)*		

(Version 1 Revised Dec 2016)

Pre-Operative Testing & Evaluation

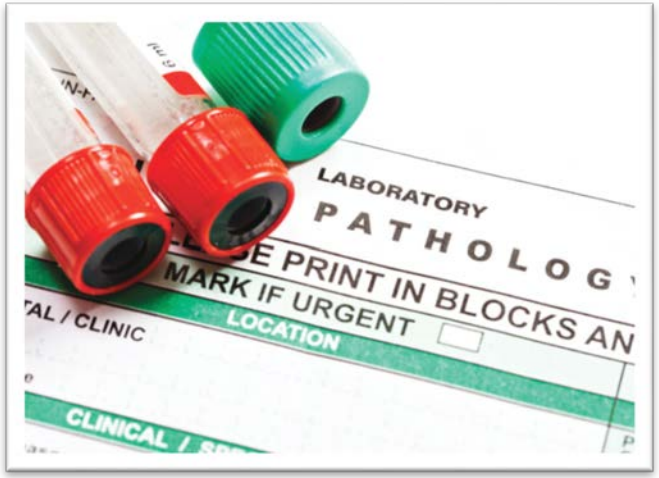
- Routine pre-op testing for healthy patients undergoing low-risk surgeries is not necessary:
  - Results are rarely being used
  - Most abnormalities found from pre-op testing are false-negative or do not affect clinical management
  - False-negative abnormalities can cause patient anxiety, delaying or cancelling procedures
- Pre-op rate of testing for low risk procedures is 21.8% in SK

Pre-Operative Testing & Evaluation

- Goal: to reduce unnecessary pre-op testing and evaluation for patients scheduled for elective surgery

- Four health regions are participating

- Draft provincial pre-op testing, consultation, and history and physical are being developed by the Clinical Development Team



Saskatchewan Pre-Operative Testing and Consultation Grid (Draft)

Guidance on Pre-Operative Testing and Consultation For Adult Patients Having Elective Surgery*

PatientFirst
Appropriateness of Care
"Better Care, Made Easier"

* For patients with complex or uncommon surgical or medical conditions, tests beyond what is suggested in this grid may be appropriate.

	Validity period of test(s) before surgery (days) if no changes in patient's health									
	30	60		90						
Risk of Surgery ↓ / **Tests →**	G&S	ECG	CXR	CBC	Renal Panel (Creat + Lytes)	PTT/INR	LFTs	Gluc	HbA1C	**Consultation ↓**
Low Risk		≥ 65 y/o								
Medium Risk (2a)		≥ 65 y/o								
Medium High Risk (2b)		≥ 65 y/o			≥ 65 y/o					
High Risk		≥ 65 y/o								Anesthetist
Surgical procedure on Group and Screen list *(As per health regions' policies)*										
Co-morbidities *(If the patient has existing co-morbidities, add the following tests as indicated)*										
Cardiovascular Diseases:										
Atrial fibrillation / History of irregular heart beat										
Defibrillator / Pacemaker										
Coronary artery disease (CAD)										Internist if ≥ 2 risk factors
Cardiac stent (< 12 months)										Internist within 12 months
History of cerebral or pulmonary vascular disease										
Transient Ischemic Attack (TIA) or stroke										Internist if ≥ 2 risk factors
Valvular heart disease / Valve replacement				If mechanical						Internist within 12 months
Heart failure										Internist if SOB with 2-block walk
Peripheral vascular disease (PVD)										
Pulmonary Diseases:										
Severe COPD; Home oxygen; Pulmonary HTN										Anesthetist AND Internist
Asthma (ER | Hospital admission within 12m)										Internist
Confirmed sleep apnea not using CPAP/ STOPBAG > 5										Anesthetist
Other Diseases (§ sign below: please see next page for more details):										
Bleeding disorders (hemophiliac | DVT) §										Hematologist within 12 months
History of anemia, bleeding disorder and / or active bleeding										
Hepatic disease §										Internist
History of electrolyte abnormality										
History of adrenal, pituitary, or major systemic endocrine disease §										
Renal disease (on dialysis or at risk for Acute Kidney Injury [AKI]) §										Nephrologist within 12 months
Diabetes (on Insulin or 2 oral agents)									Within 3m	Internist
Present malignancy / Surgery for malignancy		If on chemo	Within 6m		If on chemo	If on chemo				
Neuromuscular disorder / spinal cord lesion ↑T12										Anesthetist
Myasthenia Gravis										Anesthetist AND Internist
Difficult intubation / CA of throat / radiation of neck										Anesthetist
Use of Medications (§ sign below: please see next page for more details):										
Use of Digoxin										
Use of Lithium, Diuretics, ACE-I, ARB, NSIADS §										Internist if ≥ 2 antihypertensive
Use of Anticoagulants / Antiplatelet (ASA excluded) §										Internist
Systemic steroid use within 6 months §										Internist

SUCCESSES

- Collaborative efforts: Ministry, HQC, SMA, Senior Leaders from Health Regions, Physicians
- Alignment with CWC
- Physician interest with the right support and education
- Funding to support Clinical QI training: coaching, curriculum, faculty, data and measurement support

CHALLENGES

- We don’t know what we don’t know!
- Availability of good, real-time clinical data
- Privacy legislation
- Variation in regional policies
- Time and pace
- Communication
- Readiness and preparation for change
- Expectations

“People like to change; they just don’t like to be changed.”

Winston Churchill

The Patient's Perspective

"For so many years the patient voice has been missing in healthcare, contributing to varying outcomes for patients. By incorporating the voice of the patient throughout many areas of this work, [Appropriateness of Care] will ensure the goals of the initiative will be met. [The Appropriateness of Care Vision] Right care provided by the right provider, to the right patient, in the right place, at the right time, resulting in optimal quality care … So promising to our patients and families but also will make sure our patients will be getting the safest quality of care."

Heather Thiessen, a Patient and Family Advisor

The Patient's Perspective

"The framework and standard work for Appropriateness is so important, so that information given to patients is clear- from primary care givers to specialists. Of course, there will always be differing opinions among doctors, but patients can make better decisions when armed with good (more standard) information. We can be more involved in the decision making."

Cindy Dumba, a Patient and Family Advisor

Opportunities to Apply the AC Framework to Home Care

Key questions for Home Care organizations and providers of care:

- Is every client assessed by HC “appropriate”?
- Do assessments meet the needs of the clients?
- Is there consistency of care, and care giver?
- Does every client receive appropriate services?
- Overuse? Underuse? Misuse? Variation in aspects of HC?

Questions?

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Appropriateness of Care Webpage