Choosing Wisely Canada™

In partnership with the Canadian Medical Association

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Choosing Wisely: Addressing the Wicked Problems of Overuse

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Chair, Choosing Wisely Canada & International

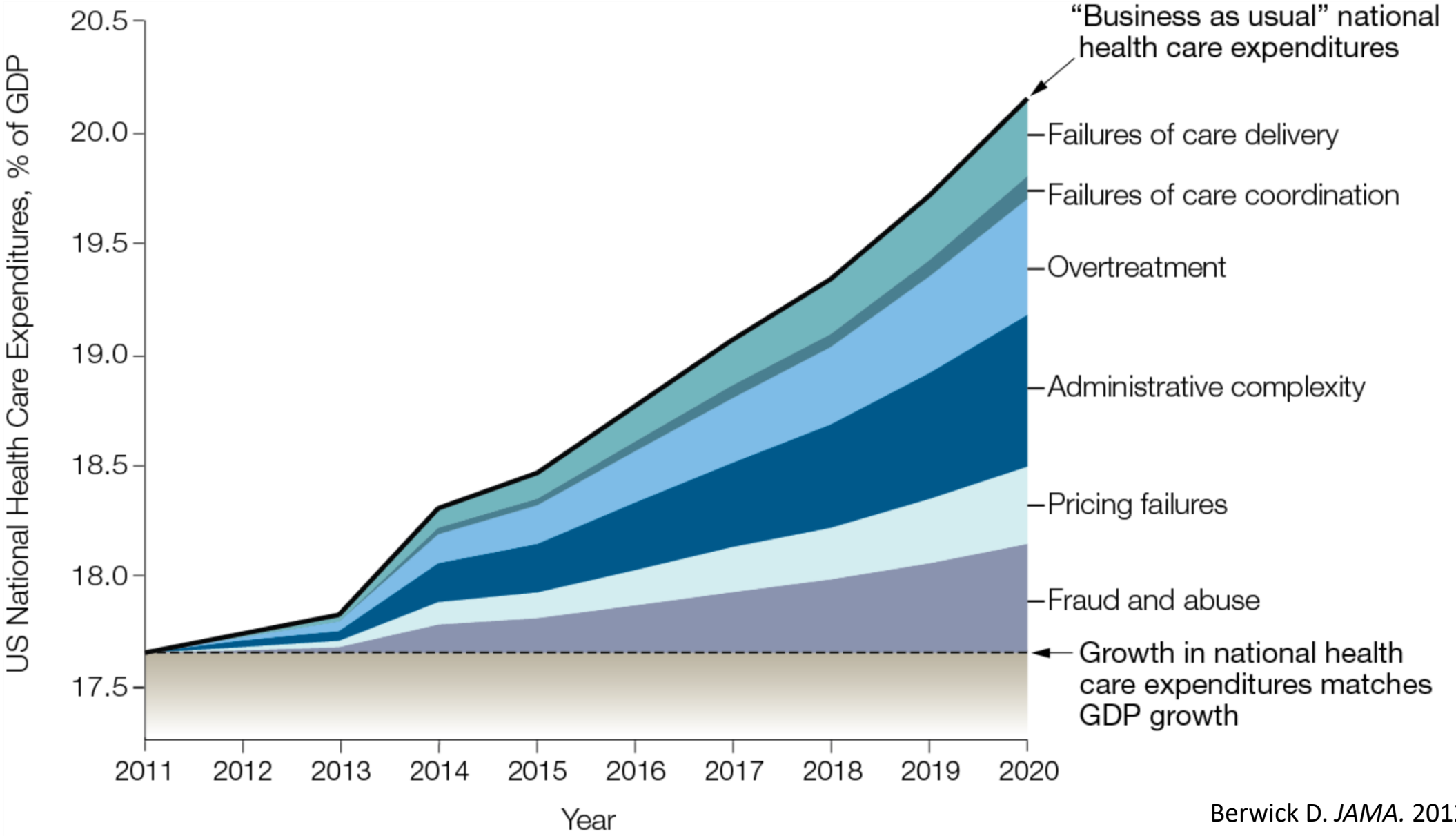
Objectives

1. To present a physician's view of why overuse of health care resources is a "wicked problem"
2. To share the approach of Choosing Wisely to addressing the problem
3. To present evidence of impact from implementation of Choosing Wisely

“Healthcare has been largely immune to the forces of disruptive innovation. Whereas new technologies, new competitors and new business models have made products and services much more affordable and accessible in fields ranging from media, telecom, finance, and retail, the US healthcare sector keeps getting costlier and is now by far the world’s most expensive system per capita”

Christensen C et al., 2017

Wedges of Waste



Berwick D. *JAMA.* 2012.

Waste in the US Health Care System

- 25% of total spending; waste in all categories
- Annual estimated costs of waste $760-935 billion
- Annual estimated savings $191-282 billion (excluding admin cost)

Shrank WH et al. *JAMA*, 2019


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

Choosing Wisely®

CELEBRATING OUR 7TH YEAR

An initiative of the ABIM Foundation

The mission of ***Choosing Wisely*** is to promote conversations between clinicians and patients by helping patients choose care that is:

- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Truly necessary

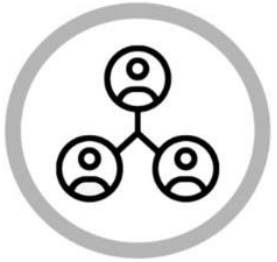
https://www.choosingwisely.org/

Campaign approach

Clinicians	• Societies develop and disseminate lists
Patients	• Develop and disseminate patient materials
Medical education	• Mobilize students and trainees • Integrate resource stewardship as a core competency
Implementation	• Support adoption of recommendations in care settings
Measurement	• Measure rates of overuse and build research capacity

What is unique about CWC?

Clinician led



Bottom up approach

Evidence-based

Simple

Choosing Wisely®
An initiative of the ABIM Foundation

American Academy of Family Physicians
AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Twenty Things Physicians and Patients Should Question

1 Don't do imaging for low back pain within the first six weeks, 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, but does increase costs. Low back pain is the fifth most common reason for all physician visits.

Symptoms must include discolored nasal secretions and facial or dental tenderness when touched. Most sinusitis in the ambulatory setting is due to a viral infection that will resolve on its own. Despite consistent recommendations to the contrary, antibiotics are prescribed in more than 80 percent of outpatient visits for acute sinusitis. Sinusitis accounts for 16 million office visits and $5.8 billion in annual health care costs.

3 Don't use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors.

DEXA is not cost effective in younger, low-risk patients, but is cost effective in older patients.

outcomes. False-positive tests are likely to lead to harm through unnecessary invasive procedures, over-treatment and misdiagnosis. Potential harms of this routine annual screening exceed the potential benefit.

5 Don't perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease.

Most observed abnormalities in adolescents regress spontaneously, therefore Pap smears for this age group can lead to unnecessary anxiety, additional testing and cost. Pap smears are not helpful in women after hysterectomy (for non-cancer disease) and there is little evidence for improved outcomes.

70 Professional Societies

350 Recommendations

88% of MDs aware of CWC

17 Medical Schools (STARS)

18% Public Awareness & 250,000 hits to website per month

2 Public Campaigns

Over 350 QI projects

Challenging Misperceptions of Patients

Screening and early diagnosis is always good

Overdiagnosis can cause harm

Benefits of treatments outweigh harms

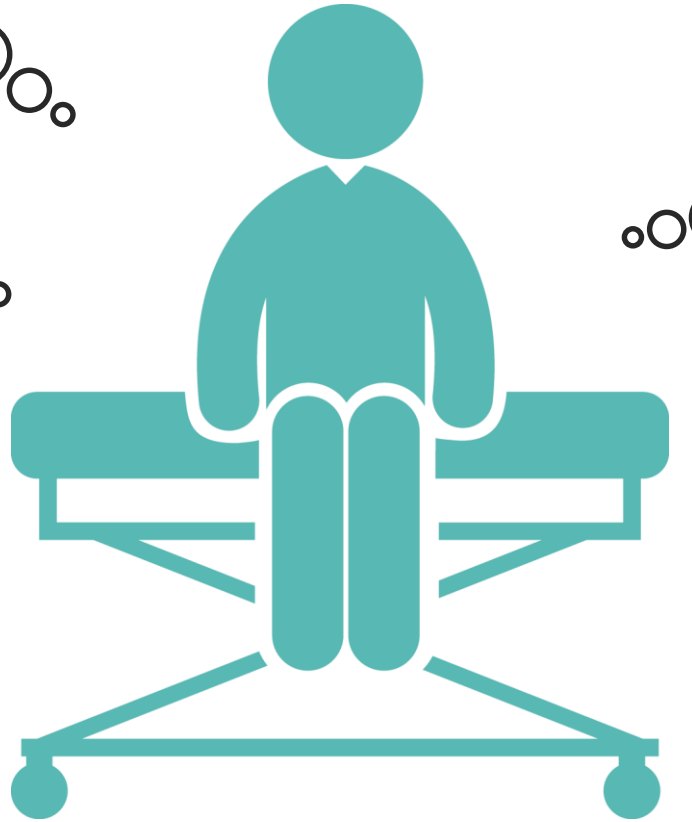
Balance between benefits and harms is often marginal or uncertain

Denial of treatment = rationing

Efficiency = better for everyone (NOT rationing)

More medicine is better medicine

Unnecessary care = unnecessary risk + cost



Doctors should just share decisions with the patients

Doctors should share decisions with patients

MORE IS NOT ALWAYS BETTER

www.ChoosingWisely.ca

MORE IS NOT ALWAYS BETTER

The same is true for medical tests and treatments. Talk with your health care provider about what you need, and what you don't. To learn more, visit www.choosingwiselycanada.org

Choosing Wisely Canada™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#klokevalg

5 QUESTIONS to Ask Your Doctor Before You Get Any Test, Treatment, or Procedure

1. **Do I really need this test or procedure?**
2. **What are the risks?**
3. **Are there simpler, safer options?**
4. **What happens if I don't do anything?**
5. **How much does it cost?** .

www.choosingwisely.org/patient-resources


Choosing Wisely Canada
STARS
Leadership Summit
STARS ESPOIRS

Choosing Wisely Canada™
In partnership with the Canadian Medical Association

FMEQ Fédération médicale étudiante du Québec

CFMS FEMC

Six Things Medical Students and Trainees Should Question

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

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.

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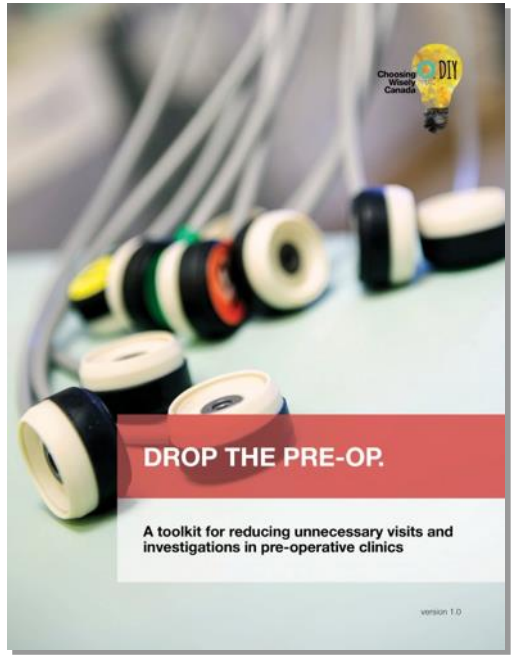
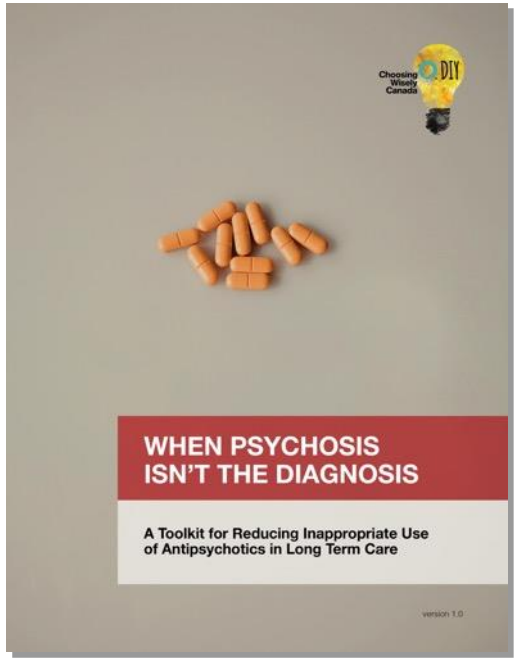
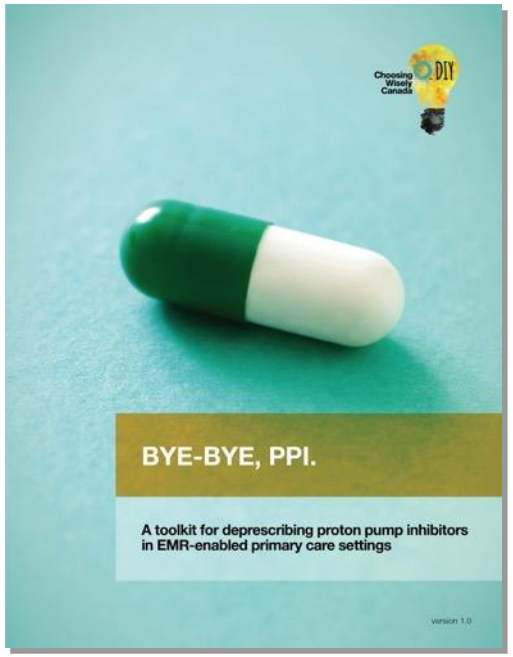
The Implementation Spectrum

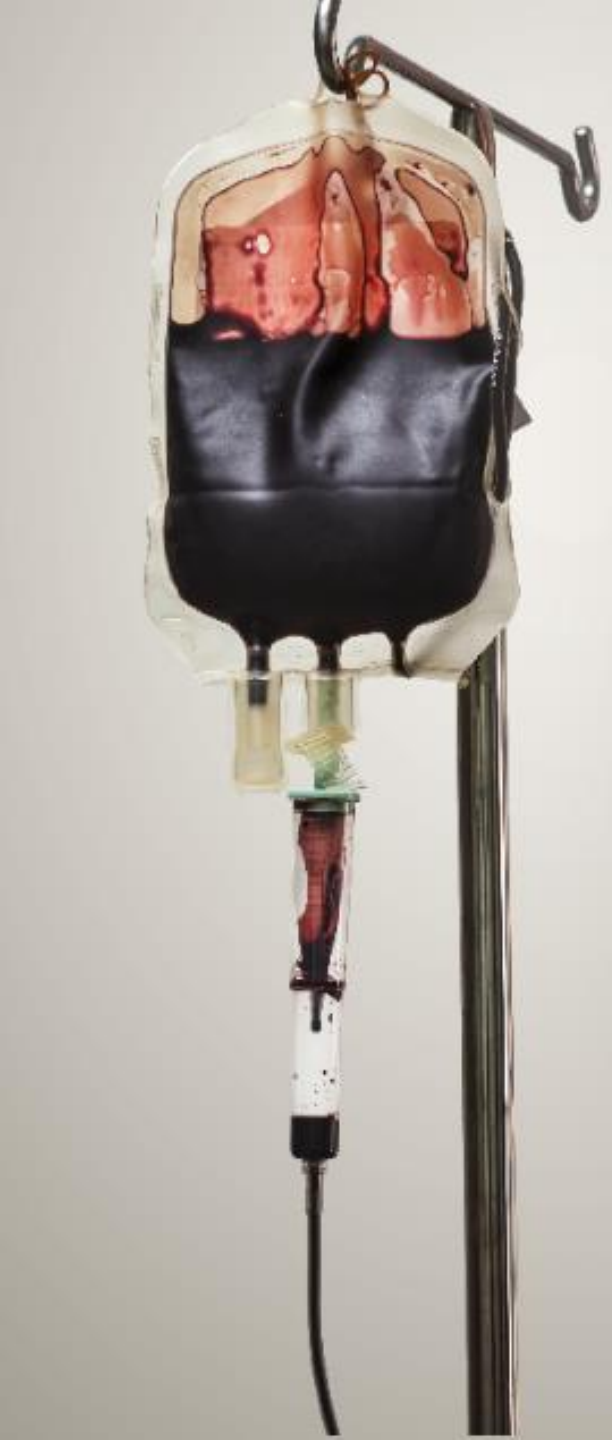
Education	Measurement & Improvement	Hard Coding
• Clinician education • Patient education • Awareness campaigns	• Performance measurement • Quality improvement projects • Audit and feedback	• Medical directives • Order sets • EMR/CPOE integration

DIY Toolkits







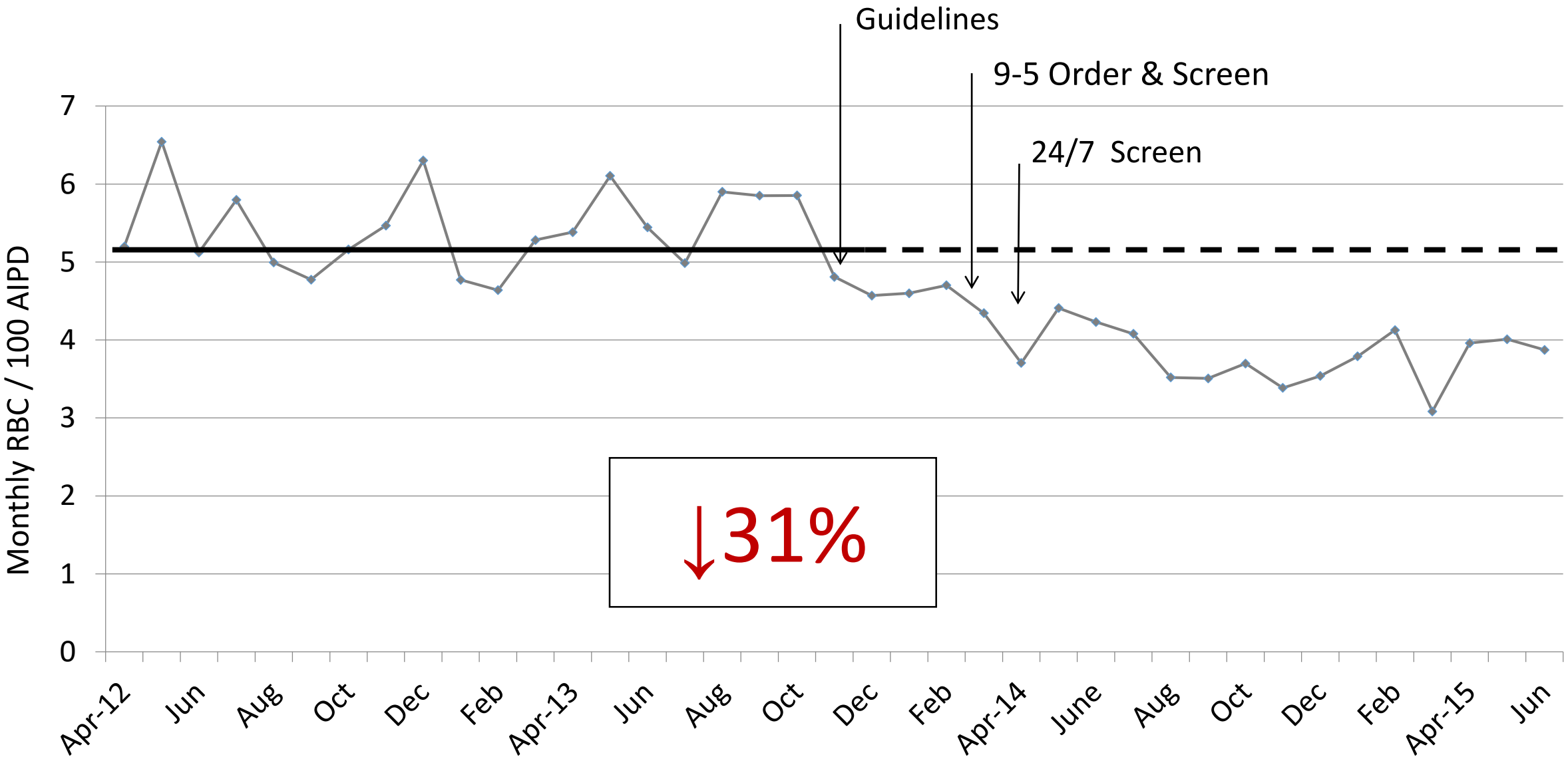


Choosing Wisely Canada DIY

WHY GIVE TWO WHEN ONE WILL DO?

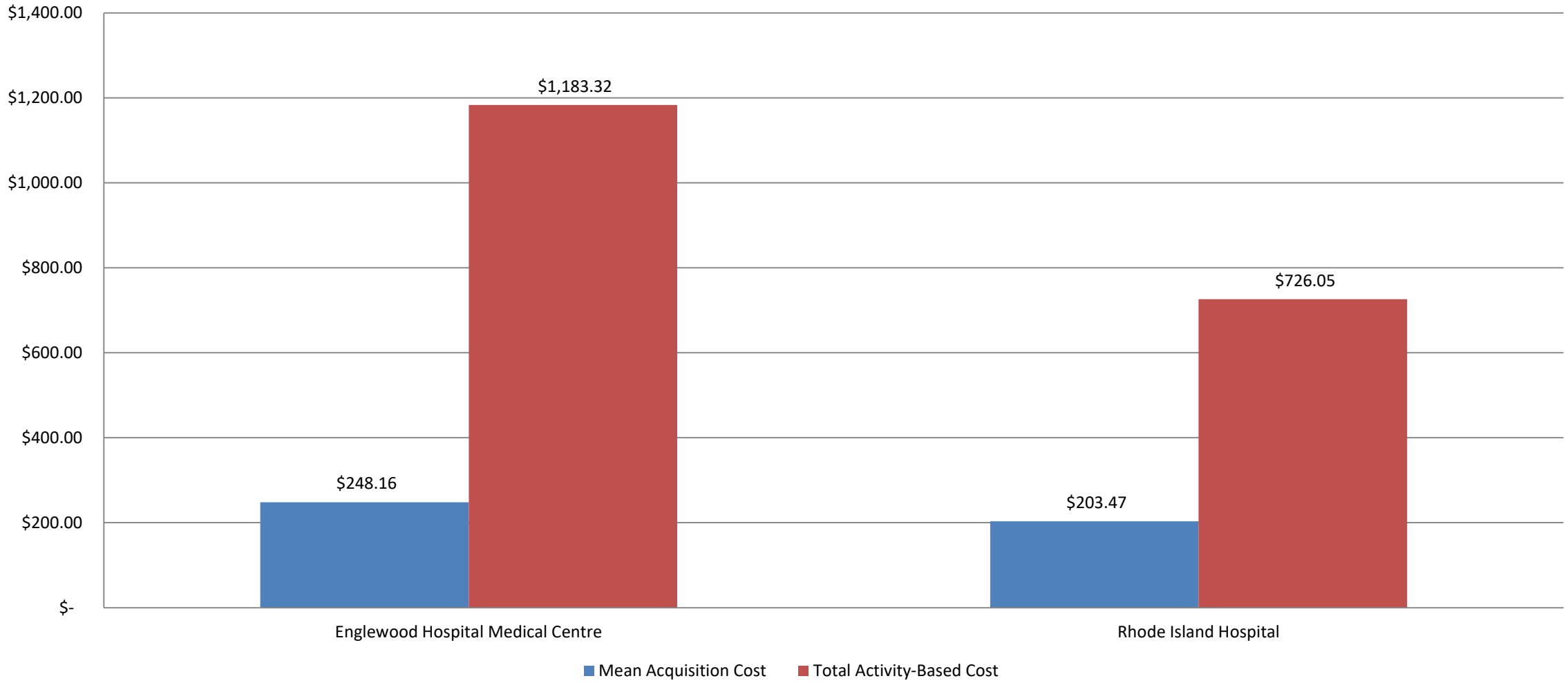
A toolkit for reducing unnecessary red blood cell transfusions in hospital

Decreasing Unnecessary Transfusions



Lin et al. Transfusion Nov 2016;56:2903-5

Activity-Based Costs of Blood Transfusions in Surgical Patients



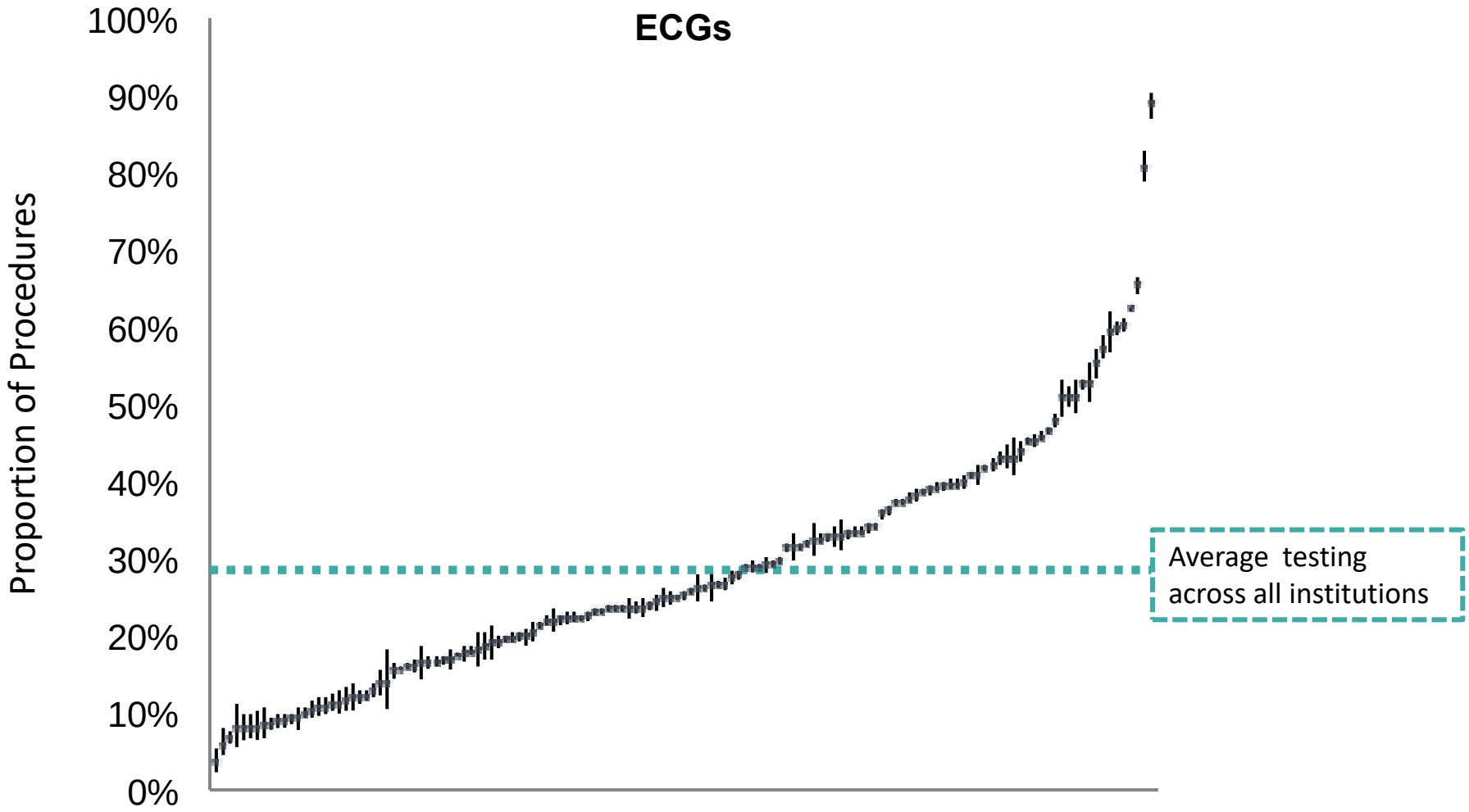
Shander et al. 2010

Choosing Wisely Canada DIY

DROP THE PRE-OP.

A toolkit for reducing unnecessary visits and investigations in pre-operative clinics

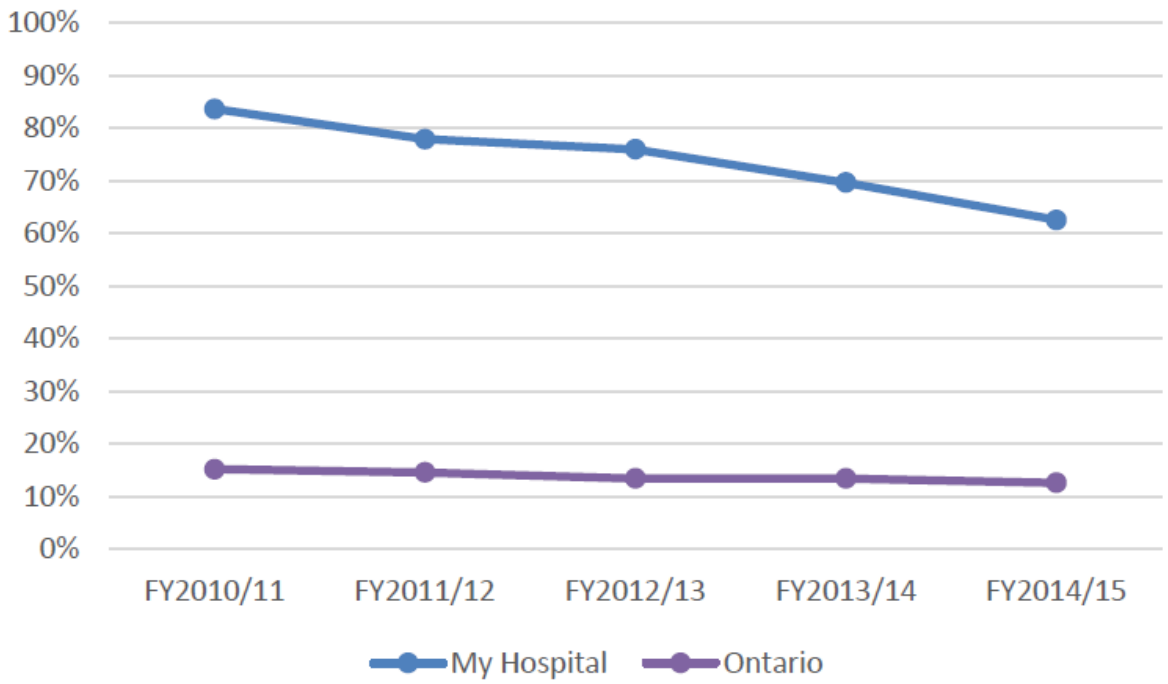
Preoperative testing in Ontario: ECGs



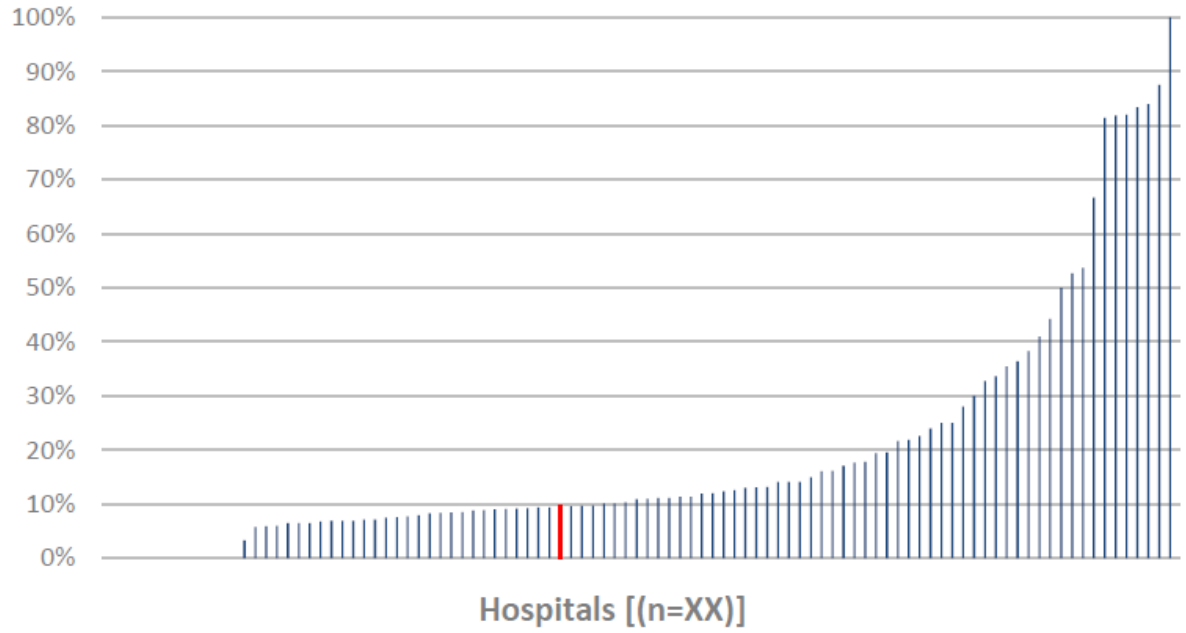
Kirkham et al. CMAJ. Aug 2016; 187(11):E349-58

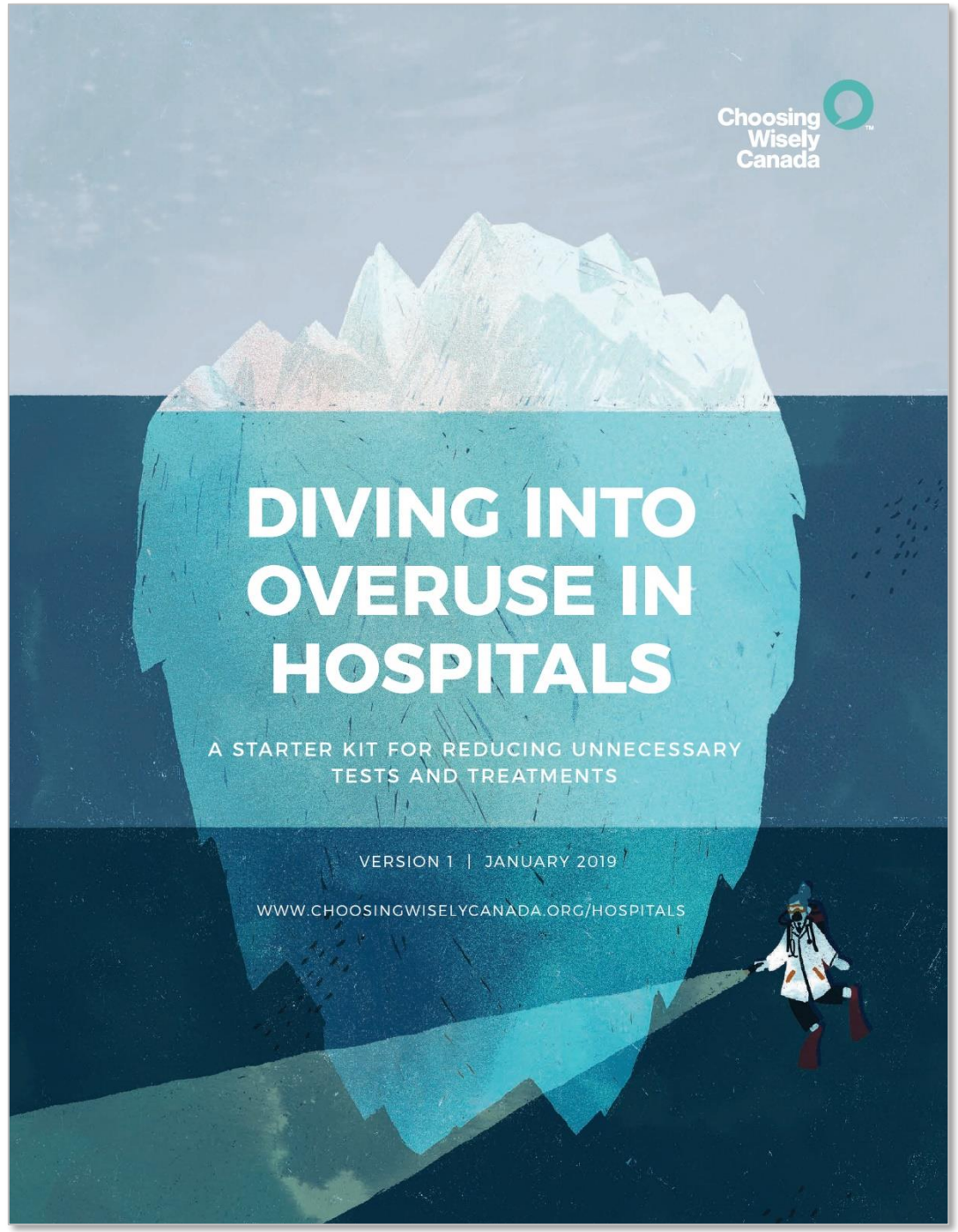
My Hospital's Performance: ECG Test before Ophthalmologic Surgery

Percentage of ophthalmologic surgery cases with pre-operative ECG, from FY2010/11 to FY2014/15



How did my hospital compare with others in the most recent year (FY2014/15)?




Choosing Wisely Canada
DIVING INTO OVERUSE IN HOSPITALS
A STARTER KIT FOR REDUCING UNNECESSARY TESTS AND TREATMENTS
VERSION 1 | JANUARY 2019
WWW.CHOOSINGWISELYCANADA.ORG/HOSPITALS

Choosing Wisely Canada Hospital Levels

	Scope of Change
Level 1	Implement the 5 “quick wins”
Level 2	Implement an additional 3 Choosing Wisely Canada recommendations through quality improvement methods
Level 3	Take organization-wide leadership on overuse and promote culture change: Choosing Wisely in strategic plan, implement 2 more recommendations, mentor another hospital

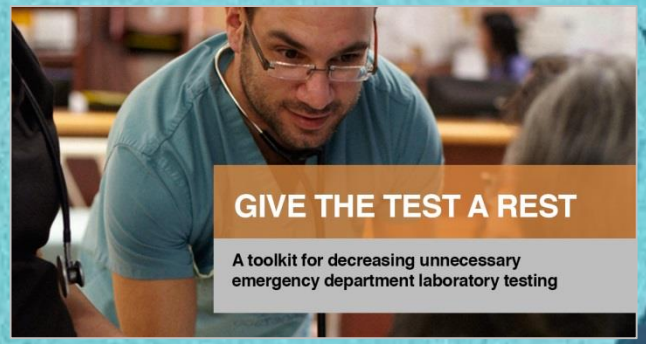
Level 1: 5 Questions/ 'Quick Wins' to Get Started

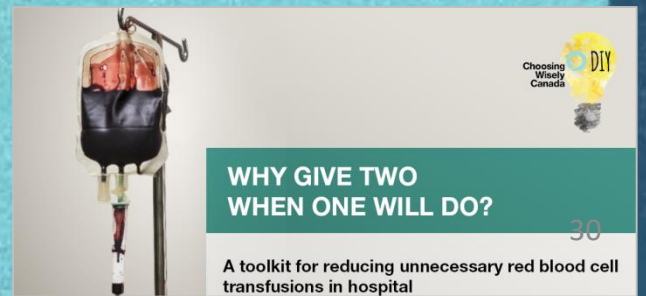
1. Does my emergency department order both PT/INR and aPTT tests as a bundle?
2. Does my hospital still use CK testing to diagnose a heart attack?
3. Are inpatients at my hospital getting daily blood tests automatically?
4. Does my hospital still test serum & RBC folate levels?
5. Does my ICU still order routine chest x-rays for all patients?

Level 2: Implementing QI Methods

What's in a toolkit?

- Key ingredients of intervention
- Key measures to track performance
- Strategies for sustaining early successes
- Additional resources and patient aids





Level 3: Organizational Leadership & Changing Culture

Measurement framework

- Provider Attitudes & Awareness
- Patient perceptions & outcomes
- Provider Behaviours: overuse of low value services
- Health systems orientation and organization

Physician Perceptions of Choosing Wisely

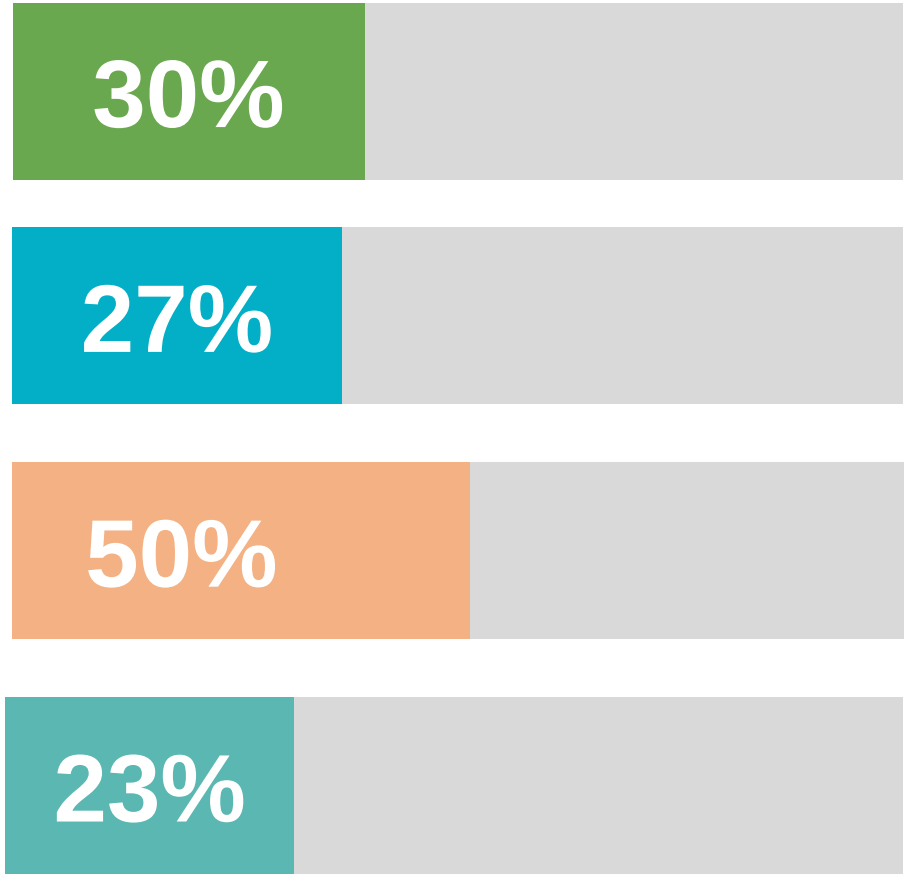
Aware of Choosing Wisely

CW valuable in helping physicians talk to patients about unnecessary tests

MDs who have seen CW materials: ↓ recommendation of tests

ABIM - PerryUndem Research/Communication – Survey, 2017

Patient Attitudes



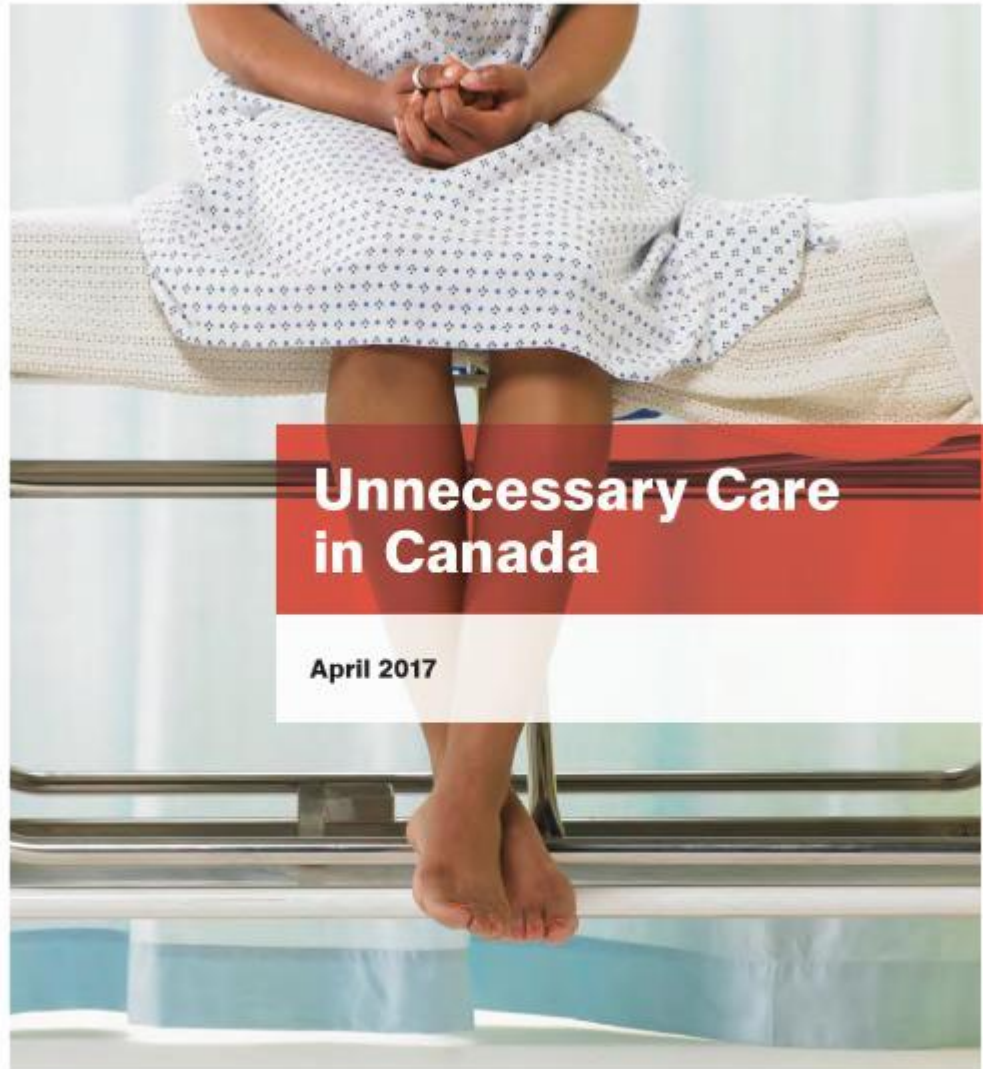
of patients said a doctor had recommended a test/treatment they did not feel was necessary

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

April 2017

Choosing Wisely Canada

Canadian Institute for Health Information
Institut canadien d'information sur la santé

Key findings

In Alberta,

30%

of patients with lower-back pain without red flags

had at least one unnecessary X-ray, CT or MRI.

In Manitoba, Saskatchewan and B.C., **rates of low-dose quetiapine** (commonly used to treat insomnia) increased among children and young adults age 5 to 24, even though this is not recommended by experts.

1 in 10 seniors in Canada uses a benzodiazepine (sedative–hypnotic) on a regular basis, even though this is not recommended by experts.

In Ontario, Saskatchewan and Alberta,

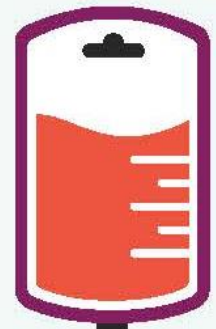
18% to 35%

of patients who had a low-risk procedure **had a preoperative test.**

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

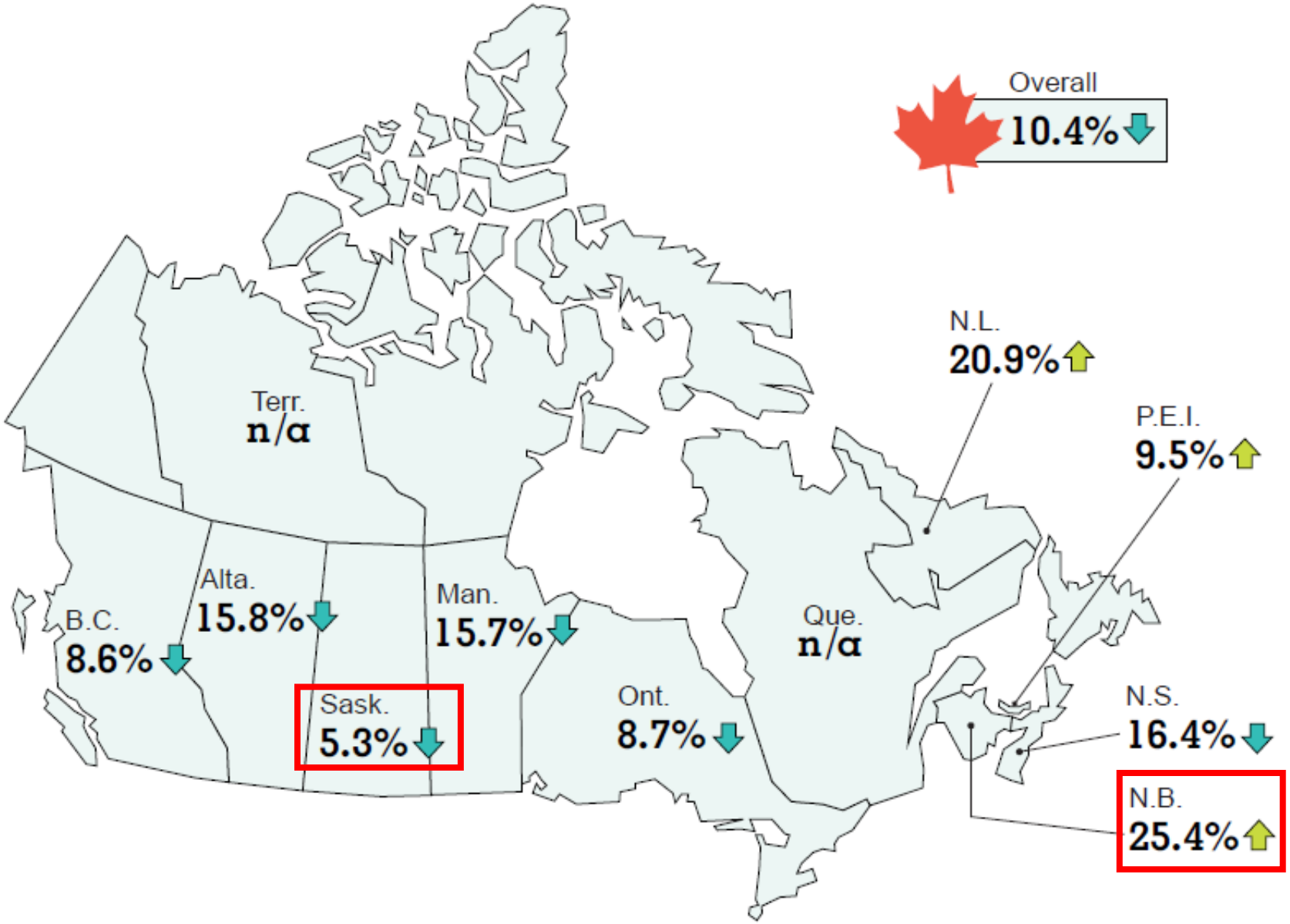
22% of Canadian women age 40 to 49 **received a screening mammogram,** despite being of average risk.

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.

Rate of Chronic Benzodiazepine use Among Seniors

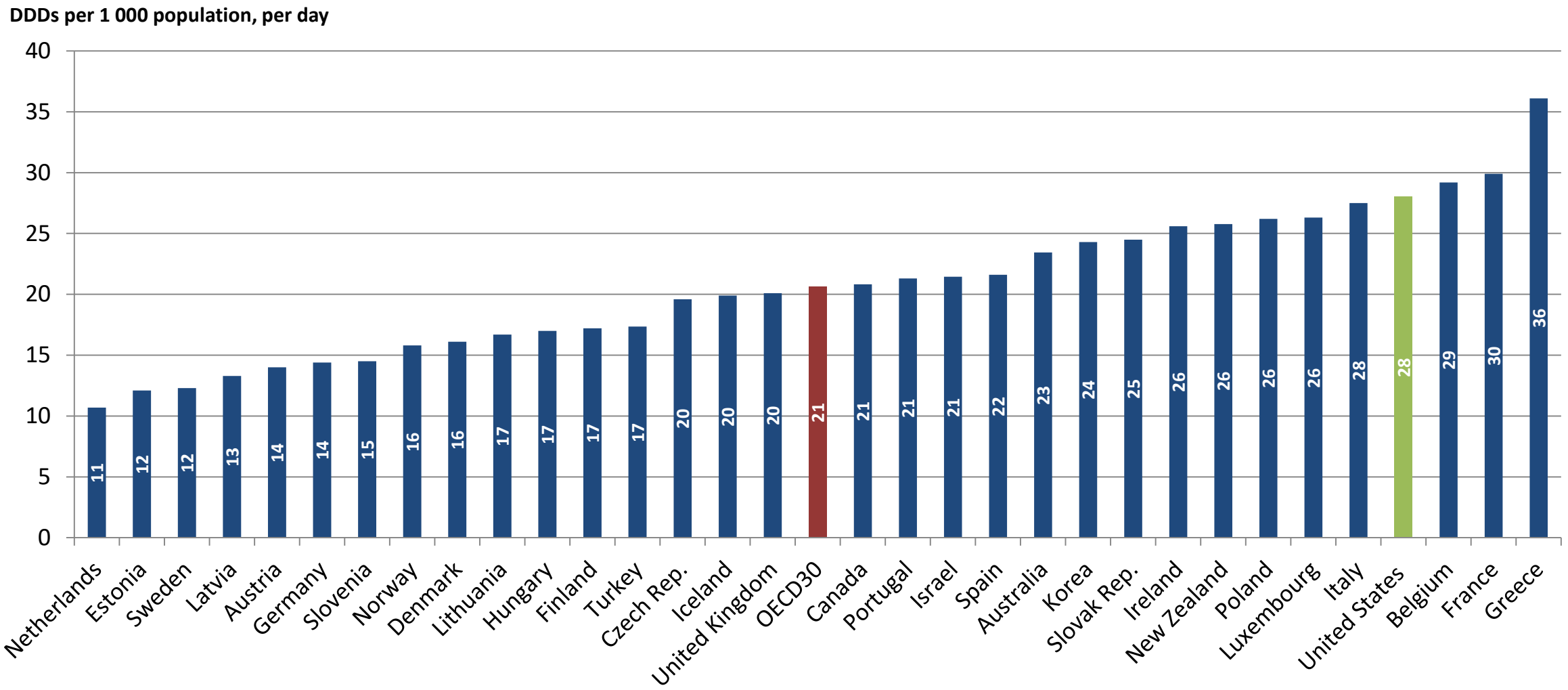


2014-2015


ORDEM E PROGRESSO

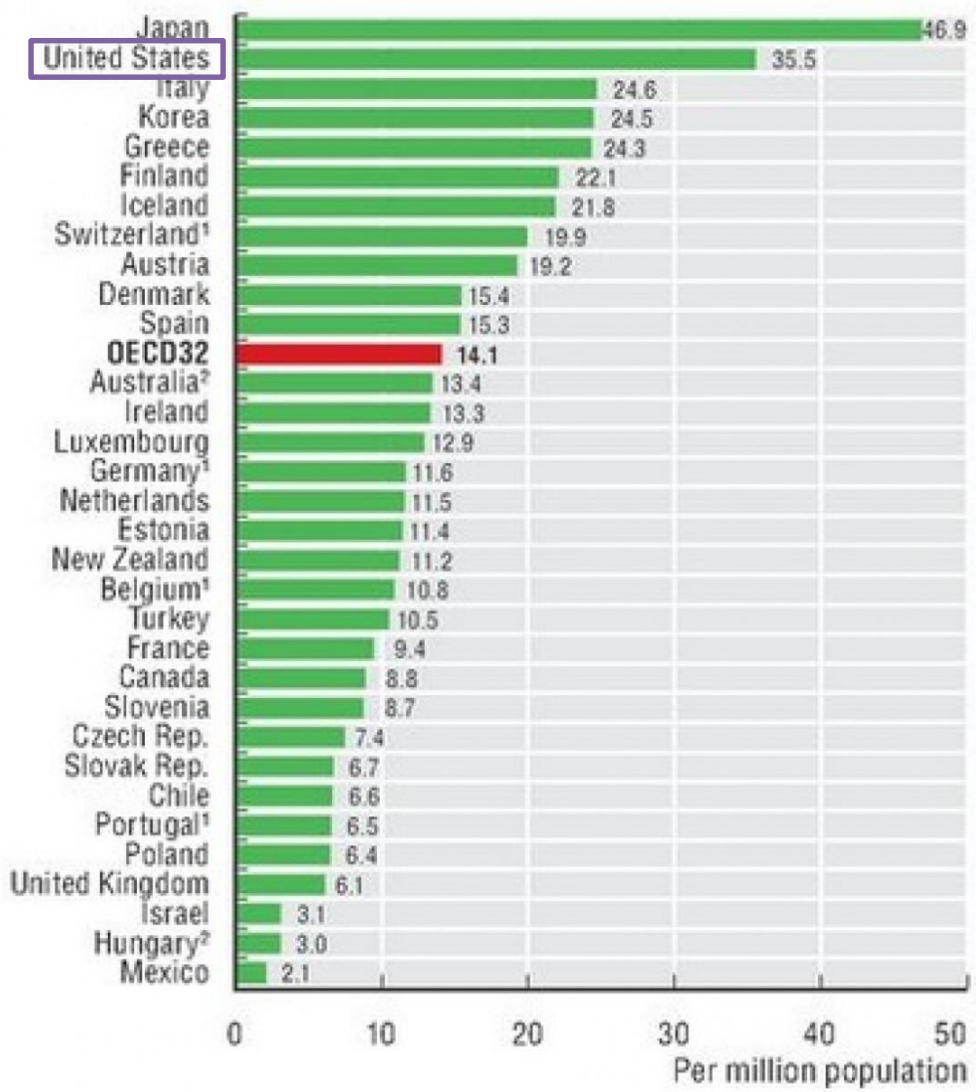
Published Jan. 10th, 2017

Antibiotic consumption across OECD countries



Source: ECDC 2017 and OECD Health Statistics 2017

MRI units across OECD countries, 2013




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
The system made me do it
Referring doctor wants it

"I want you to find a bold and innovative way to do everything exactly the same way it's been done for 25 years."

Questions & Comments

info@choosingwiselycanada.org