Choosing Wisely Canada

Christine Soong, MD, MSc, CCFP

CSHM Annual Meeting 2015

Niagara Falls

www.ChoosingWiselyCanada.org

@ChooseWiselyCA

What is Choosing Wisely Canada?

- A national campaign, led by the medical profession
- Help physicians and patients engage in conversations about unnecessary tests, treatments and procedures
- Help physicians and patients make smart and effective choices
- Ensure patients get care they need and avoid tests, treatments and procedures that could cause harm

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Medicine's Ethical Responsibility for Health Care Reform — The Top Five List

Howard Brody, M.D., Ph.D.

N Engl J Med 2010; 362:283-285 | January 28, 2010 | DOI: 10.1056/NEJMp0911423

Choosing Wisely®

An initiative of the ABIM Foundation

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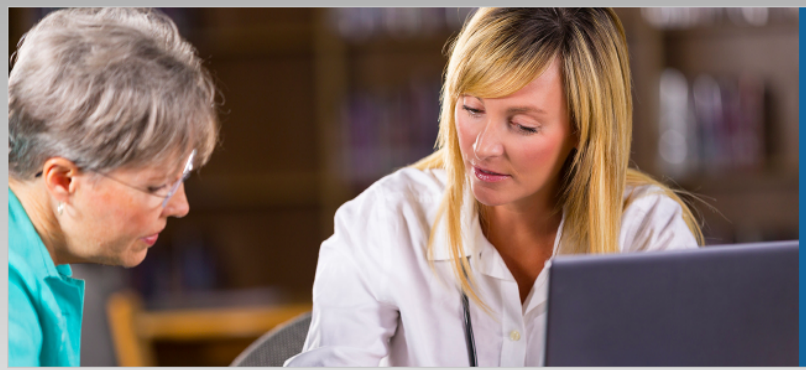

Resources

Get tools to help you Choose Wisely

ACP American College of Physicians™ Leading Internal Medicine, Improving Lives

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Public Policy

Smart Testing *offers short, clinically engaging vignettes and discussions on the appropriate use of imaging procedures and other diagnostic tests.*

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In the News

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- USPSTF Recommends Against COPD Screening In People Who Are Asymptomatic - *Lung Disease News*
- No Evidence to Support Widespread Screening for COPD: Experts - *Health*
- Ladyparts: An Owner's Manual - *Glamour*

Special Communication | LESS IS MORE

Update on Medical Overuse

Daniel J. Morgan, MD, MS; Scott M. Wright, MD; Sanket Dhruva, MD

IMPORTANCE Overuse of medical care, consisting primarily of overdiagnosis and overtreatment, is a common clinical problem.

OBJECTIVE To identify and highlight the m
related to medical overuse.

EVIDENCE REVIEW A systematic review o
related to medical overuse in adults.

FINDINGS We reviewed 478 published ar
were ranked most relevant based on qual
effects on patient care, and the number o
articles were selected using the same crit
overdiagnosis, overtreatment, and metho
interpreted for their effect on clinical me

CONCLUSIONS AND RELEVANCE The litera
2013, both clinical trials and observational s
unnecessary care. Overuse of testing causes
test results do not appear to genuinely reassure patients. Overtreatment, with both medical
therapies and procedural interventions, places patients at risk of unnecessary adverse events.

JAMA Intern Med. 2015;175(1):120-124. doi:10.1001/jamainternmed.2014.5444
Published online November 3, 2014.

Supplemental content at jamainternalmedicine.com

1. Patients **not** reassured
2. Patients at **risk** of unnecessary adverse events

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CMAJ PRACTICE CME

DECISIONS

A 62-year-old woman with syncope

Christine Soong MD MSc, Benjamin H. Chen MD, Brian M. Wong MD

A 62-year-old woman living independently presents to the emergency department after briefly losing consciousness while straining on the toilet. The patient felt well shortly before and immediately after the event; no associated trauma or confusion occurred. The patient had experienced a similar episode of syncope six months earlier, which had been investigated with an echocardiogram with a normal result. She has a known history of stroke affecting the posterior circulation and receives appropriate secondary prevention treatment (acetylsalicylic acid [81 mg/d], perindopril [4 mg/d], and atorvastatin [20 mg/d]). An initial assessment of the patient's condition shows normal vital signs, no signs of volume depletion, and normal results on cardiovascular and neurologic examination.

What diagnoses should be considered?

Syncope is a common symptom, occurring in at least 30% of the adult population.[1] The differential diagnoses in this patient's case include micturition and vasovagal syncope (neurally mediated mechanisms associated with autonomic impairment), arrhythmias, valvular disease, outflow obstruction and orthostatic hypotension.[2,3] Neurologic causes of syncope, such as transient ischemic attack (TIA), stroke or seizure, are almost always associated with features suggestive of the underlying cause (e.g., asymmetric motor weakness, and deficits in speech, vision and sensation in TIA or stroke; aura, tonic posturing and postictal confusion in seizure) and account for less than 5% of all cases of syncope.[1,4]

Are there any "red flags" on history or physical examination?

The initial history and physical examination should focus on distinguishing relatively benign causes of syncope (e.g., reflex syncope, such as vasovagal or situational syncope; orthostatic hypotension) from high-risk causes (e.g., cardiac disorders). Features suggestive of benign causes include situational precipitants such as emotional stress or activity (e.g., micturition, defecation, coughing) with an associated prodrome (e.g., nausea, sweating or dizziness), or orthostatic hypotension.[1,5] High-risk fe
"red flags," suggestive of a cardiac caus
syncope during exertion, palpitations at th
syncope, evidence of cardiovascular dis
family history of sudden cardiac death (Bo

What initial investigations are nec

Guidelines from the American College
gency Physicians and from cardiovascu
eties in Canada, the United States and
support a structured approach to the ev
of syncope.[1,6–7] If a detailed history,
examination and normal electrocardi
(ECG) suggest reflex or orthostatic sync
ther testing is usually not required.

Other cases of undiagnosed syncope
ther stratified into low, intermediate and
diovascular risk using features on his
physical examination, with the latter tw
ries warranting further tests, such as ech
raphy, rhythm monitoring (i.e., using
event or loop recorders) and stress tests.[
ratory investigations may be considered
lying causes, such as anemia, or metabol
bances, such as hypoglycemia or hyperca
suspected.[4,8,9] Further cardiac investig
admission to hospital for observation s
guided by the presence of red flags (Box

Should the patient undergo neuroimaging?

If patients presenting with simple syncc
a normal neurologic examination, neur
studies are not necessary. Observationa
involving patients presenting to the em
department with syncope found the di
yield of neuroimaging (computed tom
[CT] and magnetic resonance imaging
the brain, and ultrasonography of the
artery) to be less than 5%, with head
ultrasonography of the carotid causing
in management in less than 2% of cases
studies have led to recommendatio
Choosing Wisely Canada (Box 2), whic
limited use of neuroimaging studies in t
ation of simple syncope.[11]

JAMA Internal Medicine
Formerly *Archives of Internal Medicine*

Collections

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Less Is More

Most recent content is listed first. The collection includes content published from 1998 forward.

Research Letter | September 14, 2015 ONLINE FIRST

Low Yield of Myocardial Perfusion Imaging in Asymptomatic Patients With Atrial Fibrillation

PDF

Paul C. Cremer, MD; Amgad Mentias, MD; David Newton, MD; et al.

JAMA Intern Med. Published online September 14, 2015. doi:10.1001/jamainternmed.2015.4802

Teachable Moment | September 14, 2015 ONLINE FIRST

Diarrhea With *Clostridium difficile*–Positive Stool—Trick or Treat: A Teachable Moment

PDF

Simran Kaur Matta, MD; Alan Greenberg, MD; Aditi Singh, MD

JAMA Intern Med. Published online September 14, 2015. doi:10.1001/jamainternmed.2015.4792

Journal of
HOSPITAL MEDICINE

Journal of Hospital Medicine

Previous Issue

September 2015

Choosing Wisely®: Next Steps in Improving Healthcare Value

Jump to…

Hospitalist intervention for appropriate use of telemetry reduces length of stay and cost (pages 627–632)

David Svec, Neera Ahuja, Kambria H. Evans, Jason Hom, Trit Garg, Pooja Loftus and Lisa Shieh

Article first published online: 7 JUL 2015 | DOI: 10.1002/jhm.2411

Abstract | **Full Article (HTML)** | Enhanced Article (HTML) | **PDF(202K)**
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SCAMPs: A new tool for an old problem (pages 633–636)

Rahul H. Rathod

Article first published online: 30 JUN 2015 | DOI: 10.1002/jhm.2419

Abstract | **Full Article (HTML)** | Enhanced Article (HTML) | **PDF(332K)**
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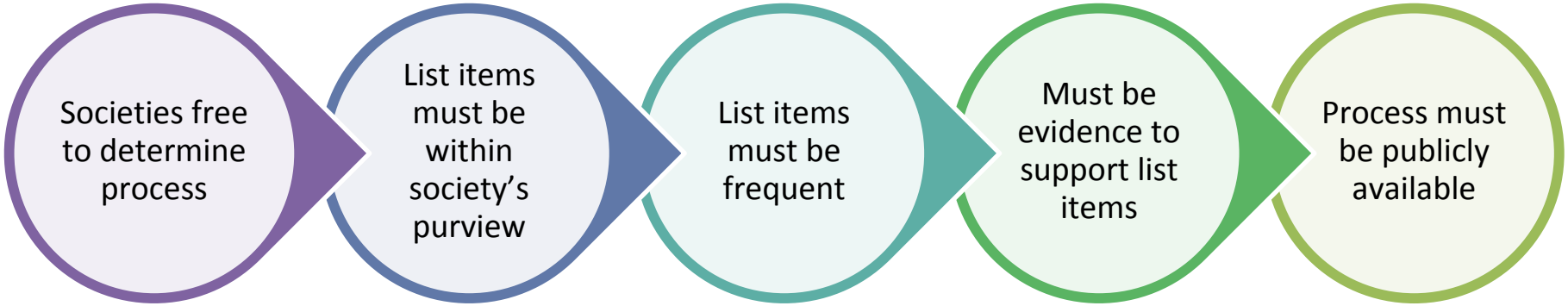
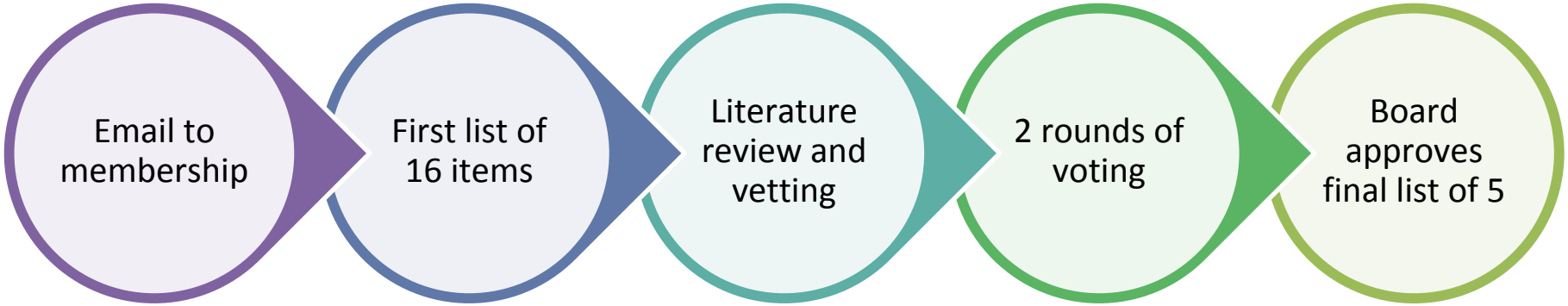
Guiding principles



How our list was created

- Multistage process combining consensus methodology and literature reviews
  - HQO, CADTH
- Led by QI committee
- Co-chairs: Christy Bussey, Christine Soong
- Admin support: Saskia van Tetering

List development



Choosing Wisely Canada™
In partnership with the Canadian Medical Association

Canadian Society of Hospital Medicine

Five Things Physicians and Patients Should Question

1 Don't place or leave in place a urinary catheter without reassessment.

The use of urinary catheters among hospitalized patients is common. Urinary catheter use is associated with preventable harm such as, catheter-associated urinary tract infection, sepsis, and delirium. Guidelines support routine assessment of the indications for urinary catheters and minimizing their duration of use. Appropriate indications include acute urinary obstruction, critical illness and end-of-life care. Strategies that reduce inappropriate use of urinary catheters have been shown to reduce health care associated infections.

2 Don't prescribe antibiotics for asymptomatic bacteriuria (ASB) in non-pregnant patients.

The inappropriate treatment of ASB represents a leading misuse of antimicrobial therapeutics. Clinicians should avoid the use of antibiotics given the lack of treatment benefits, risk of potential harm such as Clostridium difficile infections and the emergence of antimicrobial resistant organisms. The majority of hospitalized patients with ASB do not require antibiotics with the exception of pregnant women, and patients undergoing invasive urologic surgical procedures. In all other situations, antimicrobial therapy should be targeted to those who have symptoms of urinary tract infections in the presence of bacteriuria.

3 Don't use benzodiazepines and other sedative-hypnotics in older adults as first choice for insomnia, agitation or delirium.

Insomnia, agitation, and delirium commonly occur among elderly inpatients, and hospital providers frequently prescribe pharmacological sleep aids or sedatives. However, studies in older adults have shown that benzodiazepines and other sedative-hypnotics significantly increase the risk of morbidity (such as falls, delirium and hip fractures) and mortality. Use of these drugs should be avoided as first line treatment for the indications of insomnia, agitation or delirium. Instead, other non-pharmacological alternatives should be considered first.

4 Don't routinely obtain neuro-imaging studies (CT, MRI scans, or carotid Doppler ultrasonography) in the evaluation of simple syncope in patients with a normal neurological examination.

Syncope is common and has been defined as transient loss of consciousness, associated with inability to maintain postural tone and with immediate, spontaneous and complete recovery. Patients presenting with transient loss of consciousness due to neurological causes (such as seizures and stroke) are infrequent and must be differentiated from true syncope. While neurological disorders can occasionally result in transient loss of consciousness, the utility of neuro-imaging studies are of limited benefit in the absence of signs or symptoms concerning for neurological pathologies.

5 Don't routinely obtain head computed tomography (CT) scans, in hospitalized patients with delirium in the absence of risk factors.

Delirium is a common problem among hospitalized patients. In the absence of risk factors for intracranial causes of delirium (such as recent head trauma or fall, new focal neurological findings, and sudden or unexplained prolonged decreased level of consciousness), routine head CT scans are of low diagnostic yield. Guidelines suggest a step-wise approach to the management of new delirium in hospitalized patients and consideration of head CT only in patients with select risk factors.

Implementation

Vancouver Coastal Health & Providence Health Care – Oct 2014

Vancouver Coastal Health and Providence Health Care are pleased to be participating in the Choosing Wisely Canada campaign. Last fall work got underway on the first initiative being implemented across both organizations. This initiative focuses on Medical Imaging – ensuring the right MI procedures are provided to the right patients at the right time. Choosing Wisely: Medical Imaging (CWMI) supports our commitment to providing quality, patient-centred care, innovation, and sustainability.

Under CWMI, physicians and staff are reviewing Medical Imaging testing for five common clinical scenarios based on the list developed by the Canadian Association of Radiologists and American College of Radiology (CAR/ACR), with one additional opportunity identified specifically to meet the needs of our patients and physicians.

Multidisciplinary teams made up of physicians, staff, administrators and members of the public are involved in planning, implementation a
being used appro
resources/capaci
replicate the proj

We are implemer
rolled out in hosp
will be reported

North York General Hospital, Ontario – January 2015

Inspired by the success of the Choosing Wisely® campaign in the United States, North York General Hospital (NYGH) was one of the first hospitals to join the *Choosing Wisely Canada* campaign in June 2014. With a strong history of providing the best quality care, at the right time, in the right place, we built on the successful use of our computerized provider order entry system, advanced electronic medical record, clinical order sets and patient flow strategies to introduce Choosing Wisely.

Following the launch, we engaged hospital leadership and clinical chiefs in reviewing *Choosing Wisely Canada's* recommendations and asked our experts to suggest additional ones. Patient and family engagement continues to be a critical component of our *Choosing Wisely* campaign with a patient advisor engaged in campaign discussions since its inception. In addition, we are engaged in ongoing discussions with our Patient- and Family Centred-Care Advisory Council on how best to engage patients and families.

To date it has received valuable feedback and insights from all of its physician groups with recommendations and opportunities for implementation. Incorporation of approved recommendations into its order sets and medical directives is complete. The impact of these changes is noted most in the Emergency Department (ED), where NYGH has achieved a 40% decrease in laboratory testing for ED patients as a result of Choosing Wisely campaign efforts, without any observable change in outcomes.

LESS IS MORE

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HOME DISCOVER ACT BLOG [FRANÇAIS] ABOUT

"Cured yesterday of my disease, I died last night of my physician"

– MATTHEW PRIOR

Choosing Wisely Canada Profile: Dr. Jessica Otte

Meet our British Columbia Clinical Leader, Dr. Jessica Otte. A Nanaimo, BC based family physician, part-time rural GP in Nunavut and the Northwest Territories, and founder of lessismoremedicine.com.

Dr. Otte is committed to transformation and advocacy for higher quality health care in

How will you implement Choosing Wisely into your practice?

- 2 out 5 winning QI oral abstracts were based on CWC themes

We want to hear your stories!

Acknowledgements

- Christy Bussey
- Saskia van Tetering
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