Choosing Wisely Canada

Choosing Wisely Manitoba (CWMB)

Physician Leadership in Resource Stewardship

Community Based CPD Program
Steinbach, December 5, 2018

ChoosingWiselyManitoba

DIAGNOSTIC SERVICES MANITOBA

GEORGE & FAY YEE Centre for Healthcare Innovation

Faculty/Presenter Disclosure

Jim Slater, Chief Operating Officer & Provincial Lead Health Support Services

Executive Sponsor: Choosing Wisely Manitoba and Personalized Medicine Manitoba

Instructor, Department of Pathology, Max Rady College of Medicine, Rady Faculty of Health Sciences, University of Manitoba.

Instructor, Health Services Leadership and Management, School of Continuing Education, Red River College

1502-155 Carlton St, Winnipeg, MB, R3C 3H8

T: 204-926-7188; E: jslater@sharedhealthmb.ca

Conflict of Interest/Commercial Relationships: N/A

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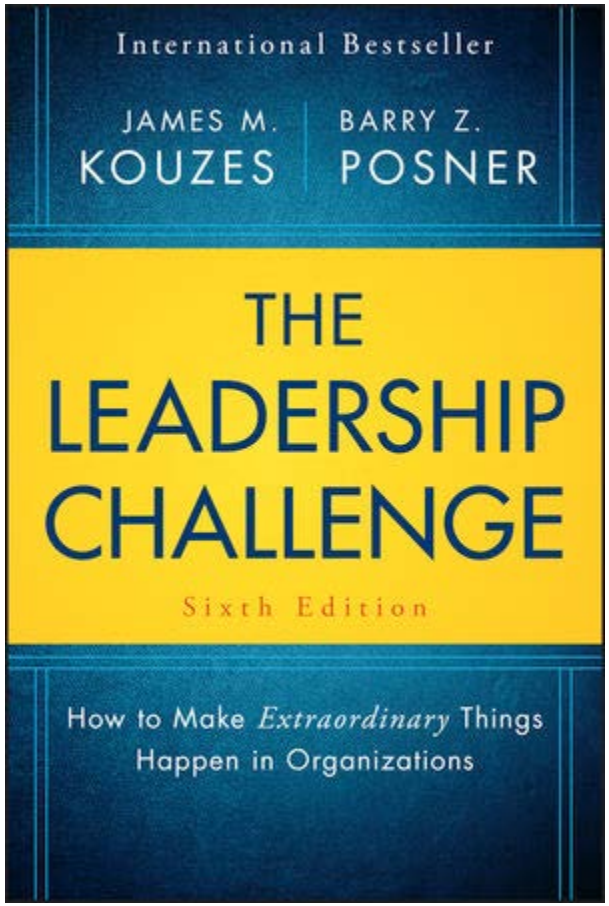
Objectives:

- Discuss the basics of resource stewardship in healthcare and understand the critical role of physicians and other health care professionals
- Discuss the importance of using resources “appropriately” and why Choosing Wisely Manitoba is gaining support
- Learn about the new Provincial Health Organization – Shared Health and its role in Provincial Clinical Guidelines
  - Where does Choosing Wisely Manitoba, physician leadership and resource stewardship fit?
- Engage in discussions to develop opportunities for “Choosing Wisely” and reinvesting in improving care

Resource Stewardship

- Resource stewardship is the appropriate and responsible use of resources to achieve ***high value, effective care***.
- Direct link to both ***quality*** and ***safety***:
  - Underuse
  - Misuse
  - Overuse

1. Royal College of Physicians & Surgeons of Canada
2. Berwick, DM. 2002.A User's Manual for the IOM's 'Quality Chasm' Report. Health Affairs. 21(3): 80-90.



http://www.leadscanada.net/

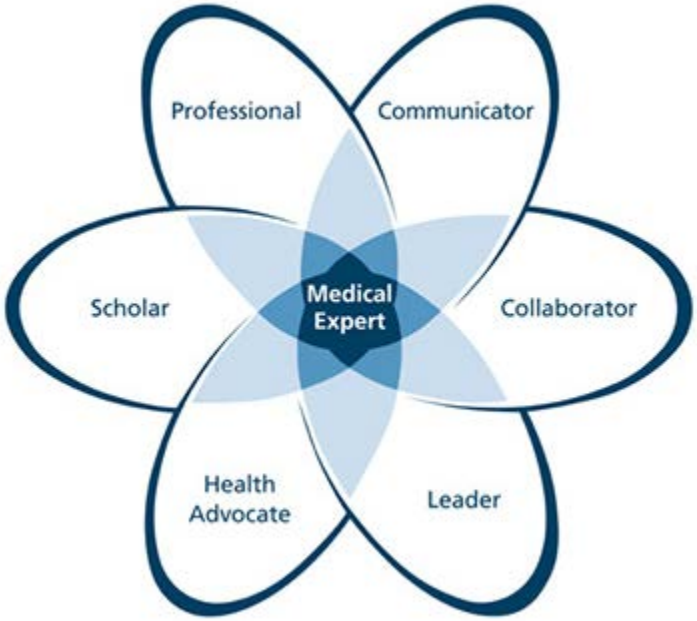
CanMEDS 2015

Physician Competency Framework

ROYAL COLLEGE
OF PHYSICIANS AND SURGEONS OF CANADA

EDITORS
Jason R. Frank
Linda Snell
Jonathan Sherbino

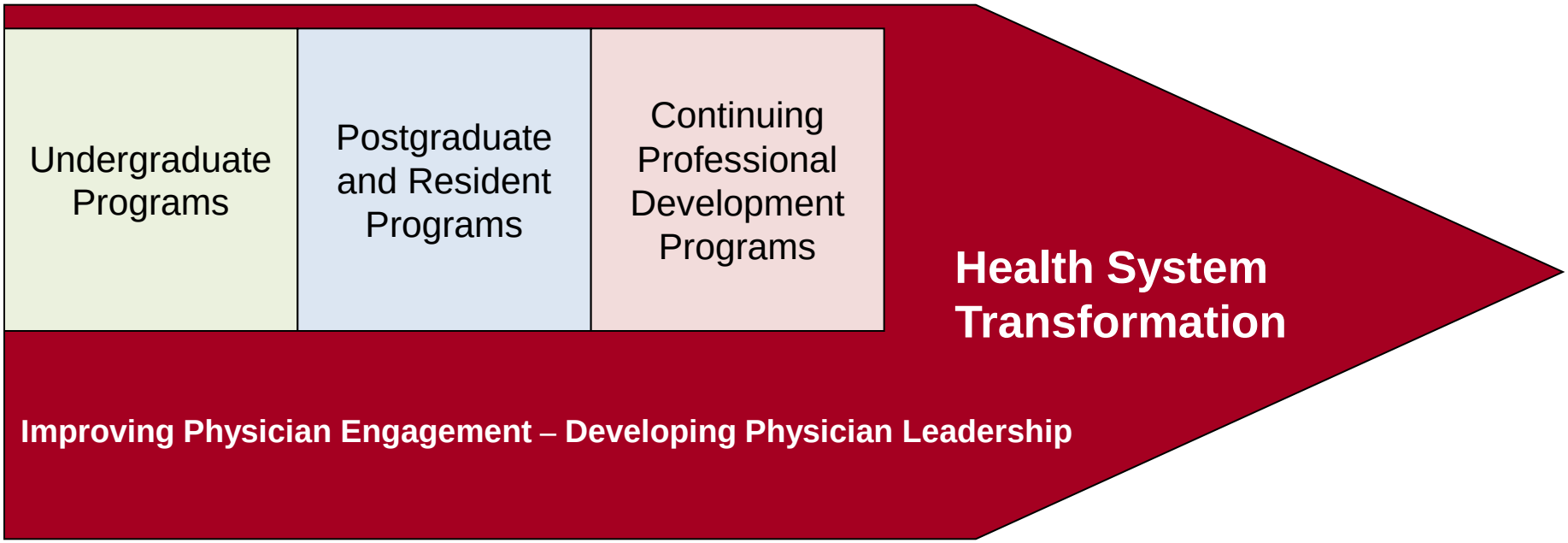
This framework is proudly endorsed by 12 Canadian medical organizations



Key Concepts

- Consideration of justice, efficiency, and effectiveness in the allocation of **health care resources** for optimal patient care
- Allocate **health care resources** for optimal patient care
- Apply evidence and management processes to achieve **cost-appropriate** care
- Mobilizing **resources** as needed
- Work with patients to address determinants of health that affect them and their access to needed health services or **resources**
- **Evidence**-informed decision-making
- Integrate best available **evidence** into practice

Physician Engagement and Leadership

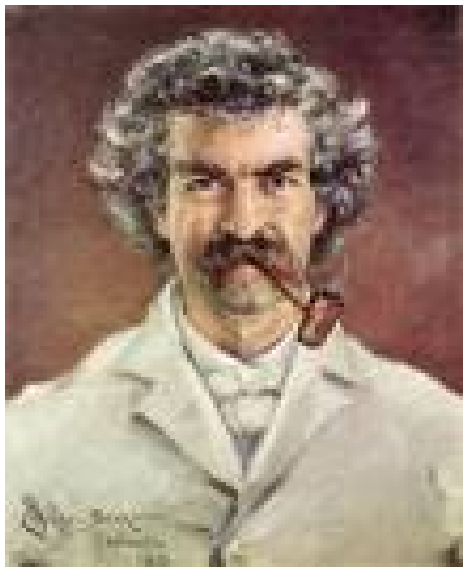


Facilitating Change across Professional Cultures

- Any form of change requires a shift of behavior.
- Professionals tend to resist change, operating instead on the premises of internalized norms and care strategies, developed through professional socialization, training, experience, peer culture and organizational structures.
- The leader must take care to determine which tool and which approach are most appropriate to the context of the change and the scope and breadth of the change.

"It's amazing what can be accomplished if the leader doesn't care who gets the credit."

Mark Twain



Just Say No: 10 Common Medical Tests That May Do More Harm Than Good

Forbes

Melanie Haiken, CONTRIBUTOR

Stop! Do you really need that PSA test or pap smear? Did you know experts don't think most women shouldn't have a bone density test? And what about heartburn - did you know that your PPI (proton pump inhibitor) might be doing more harm than good?

Too Many Tests Can Cause Lifelong Harm – A *Choosing Wisely* Patient Story

January 14, 2016

This is one in a series of patient stories collected by Consumer Reports to share how people are Choosing Wisely about their health care.

"I've had 17 MRIs since the year 2000 due to some chronic pain issues, mostly in my back. That was 15 too many.

Chronic pain can be frustrating for a doctor, and my MRIs were handed out like candy. Most of them f their office to 'prove' nothing was wrong with me. They're even ave mild back pain.

U.S. EDITION Mon, Mar 05, 2018 **Newsweek**

U.S. | World | Business | Tech & Science | Culture | Sports | Health | O

SOME MEDICAL TESTS, PROCEDURES DO MORE HARM THAN GOOD

BY SHARON BEGLEY ON 8/14/11 AT 10:00 AM

CTV NEWS Video Shows Canada World Politics Entertainment Sci-Tech Health Autos Business Sports CTV News

Unnecessary tests draining Canada's health care system, prolonging wait times: report

CBC news | Manitoba

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Canada > Manitoba

OPINION | Unnecessary medical tests potentially harmful, strain Canadian health-care system

Outcomes for patients could be improved by ending unnecessary tests, says Choosing Wisely Canada

By Wendy Levinson, for CBC News Posted: Apr 22, 2017 5:00 AM CT | Last Updated: Apr 22, 2017 5:00 AM CT

CNN Health » Too many medical tests may harm, not help, older patients Live TV U.S. Edition +

Too many medical tests may harm, not help, older patients

By Liz Szabo, Kaiser Health News

Updated 4:24 AM ET, Wed January 3, 2018

ChoosingWiselyManitoba

CANADA July 14, 2017 2:15 pm Updated: July 14, 2017 2:38 pm

Canada's health-care system is third-last in new ranking of developed countries

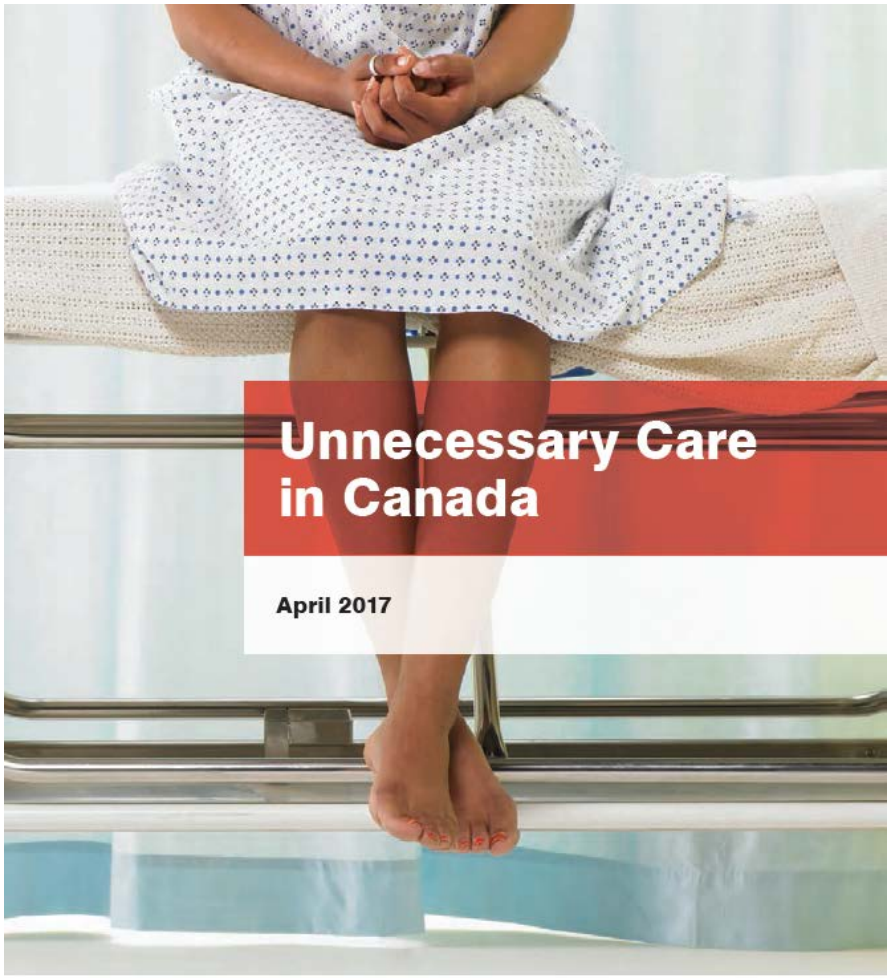
By Monique Scotti National Online Journalist, Politics Global News

Health care in 'crisis' – Canadian Medical Association pushes for national standards

EMMA GRANEY

More from Emma Graney

Published on: July 16, 2017 | Last Updated: July 16, 2017 7:20 PM MDT



Wait Times for Priority Procedures in Canada, 2017

Choosing Wisely Canada

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

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

OFFICE OF THE AUDITOR GENERAL MANITOBA

Department of Health, Seniors and Active Living
Diagnostic Services Manitoba
Prairie Mountain Health
Winnipeg Regional Health Authority

Management of MRI Services

April 2017

Web Site Version

healthintelligenceinc.
and associates

PROVINCIAL CLINICAL AND PREVENTIVE SERVICES PLANNING FOR MANITOBA

Doing Things Differently and Better

Final Report
Submitted to Project Advisory Committee

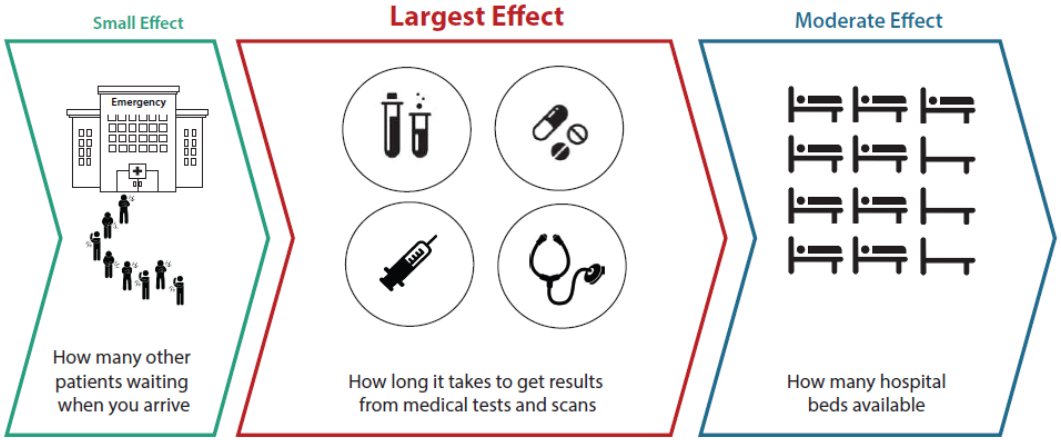
January 13, 2017

KPMG

ChoosingWiselyManitoba

Medical tests and scans done in the ER help doctors treat patients, but can be very time consuming. It's important that ER doctors agree on when these tests are truly needed. Healthcare planners could also focus on ways to admit patients to hospital more quickly once it's decided that a hospital stay is needed.

Figure 3. The Most Important Factors for Emergency Room Wait Times



What does the system look like?

1,300,000 citizens

Population by region

NRHA – 5.7%

PMH – 12.8%

SHSS – 14.7%

IEHRA – 9.6%

WRHA – 57.1%

Rural/urban

Rural 25%

Urban 75%

French as first language

French (41,365)

First Nations

Inuit and other peoples (2,835)

Metis (78,835)

First Nations (114,230)

Special care populations

Elderly (199,865)

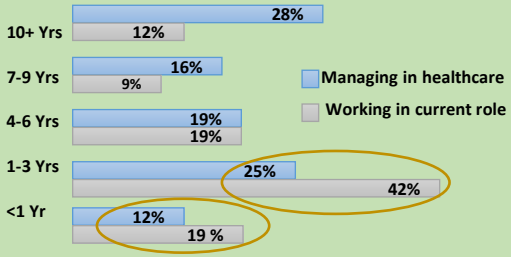
Mental Health (283,552)

Chronic Conditions (331,828)

55,400 employees

Workforce

Experience of front line managers



71% front line managers who do not feel adequately trained to use available information resources to make effective management decisions

45% front line managers who do not feel proficient with spreadsheet software

Complex system with $6.0B annual spend

Core organizational environment

3	Funding Departments
8	Health Authorities
200+	Delivery & stakeholder organizations
187	Bargaining units
7,500+	Number of business processes
700+	Number of computer systems
68,000+	Number of supply chain materials

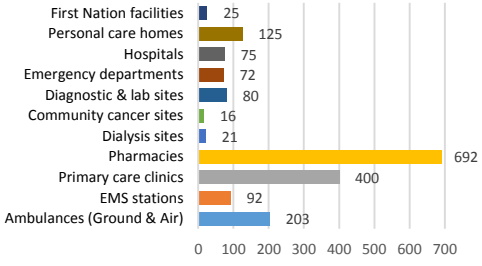
Jurisdictional partners

2	Federal departments
9	Cities
70	Towns/villages
135	Rural municipalities
63	First nations communities

Statutes and agreements

56	Statutes
100+	Regulations
182	Collective agreements
250	Service purchase agreements

Facilities



Customers | **Workforce** | **Systems & processes**

*Various sources including MHSAL estimates. Front line manager findings from WRHA 2017. Actual figures need verification before communication with the public or system stakeholders.

What does the system look like?

Provincial Health Expense Comparison (2013)

		Ratio of Manitoba Expenses to Manitoba Expenses at per Capita Rate of:			
Expense Category*	**Manitoba Expenses (in $millions)**	**Ontario**	**Saskatchewan**	**Alberta**	**BC**
Hospital	$ 2,300	1.30	1.09	0.75	1.13
Other Institutions	$ 810	**1.58**	1.01	**1.13**	**1.62**
Physicians	$ 1,090	0.94	0.98	0.83	1.07
Drugs	$ 300	0.75	0.84	0.65	1.28
Capital, Public Health, Administration, Other	$ 1,240	**1.49**	1.03	**1.27**	**1.59**
Total Expenses	**$ 5,740**	**1.23**	1.03	0.88	**1.26**

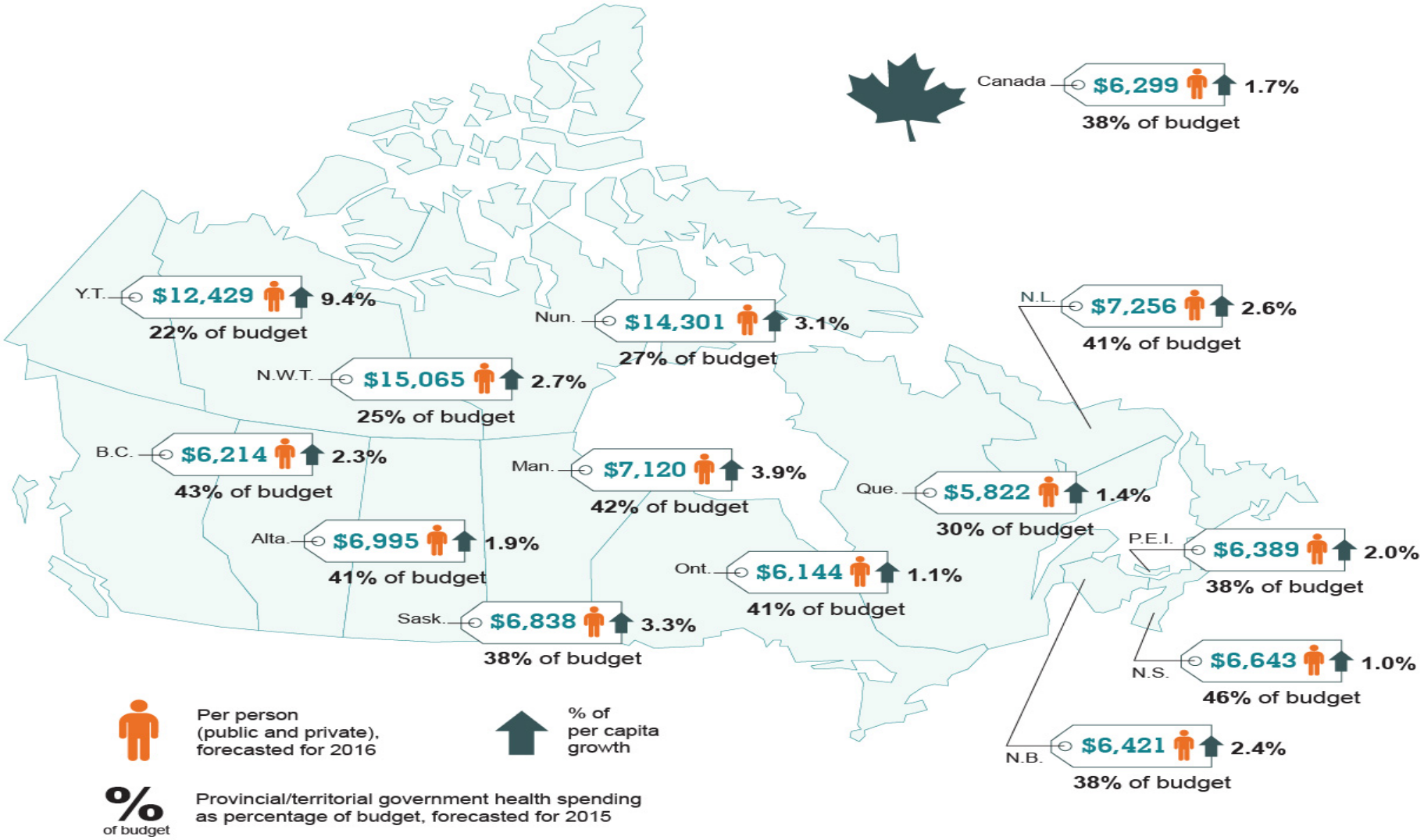
What does the system look like?

Indicator	Canada	Manitoba	Manitoba Ranking	Year
Hip Fracture Surgery within 48 Hours	87.5%	96.1%	1/9	2016/2017
Ambulatory Care Sensitive Conditions Hospitalizations	325 per 100,000	301 per 100,000	2/12	2016/2017
Medical Patients Readmitted to Hospital	13.7%	12.9%	3/12 (tied)	2016/2017
Surgical Patients Readmitted to Hospital	6.9%	6.0%	2/12	2016/2017
Repeat Hospital Stays for Mental Illness	12.1%	9.4%	1/12	2016/2017
Inpatient Average Length of Stay	7.0 days	9.6 days	**12/12**	2016/2017
ED Wait Time for Physician Initial Assessment (90th percentile)	3.1 hours	5.1 hours*	**7/7***	2016/2017
Total Time Spent in ED for Admitted Patients (90th percentile)	32.6 hours	43.5 hours*	**7/7***	2016/2017
Hip or Knee Replacement within 6 Months	71%	47%	**9/10**	2017/2018
Cataract Surgery within 112 Days	71%	32%	**10/10**	2017/2018

***Note: ED wait time information is only available for the WRHA, and ED rankings include two provinces (SK and NS) that also do not have all facilities submitting**

Source: Canadian Institute for Health Information

How do the provinces and territories compare?



Source
National Health Expenditure Database, Canadian Institute for Health Information.

Doing the Right Thing…

Do the right thing…

…at the right time…

…for the right reason

the patient!

…isn't supposed to be easy!!!

Where is the real value for money?

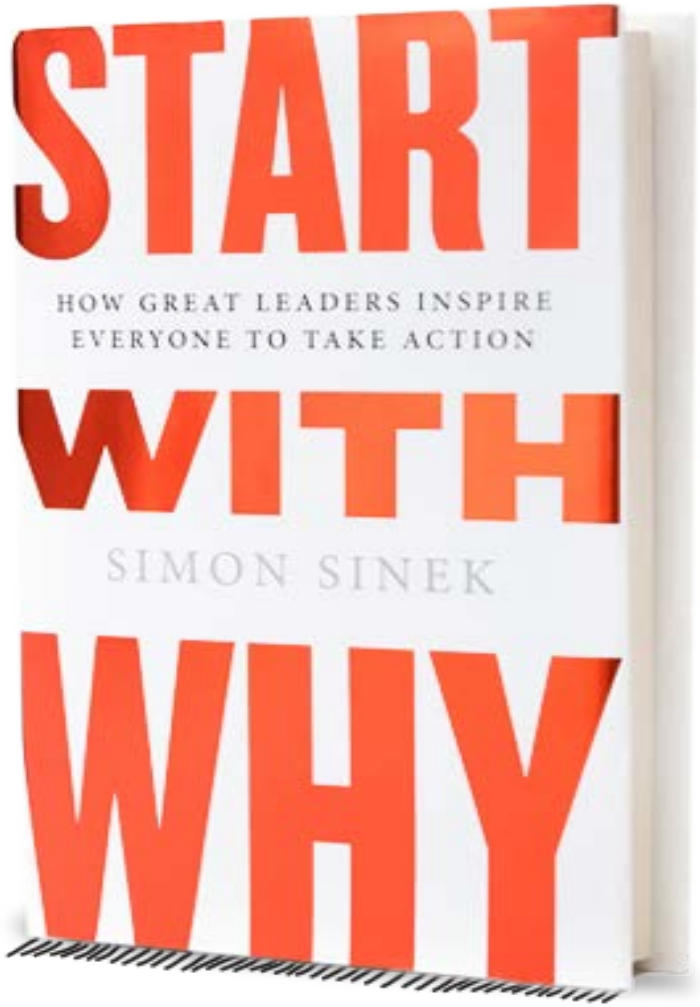
You have to look below the surface of superficial "savings"

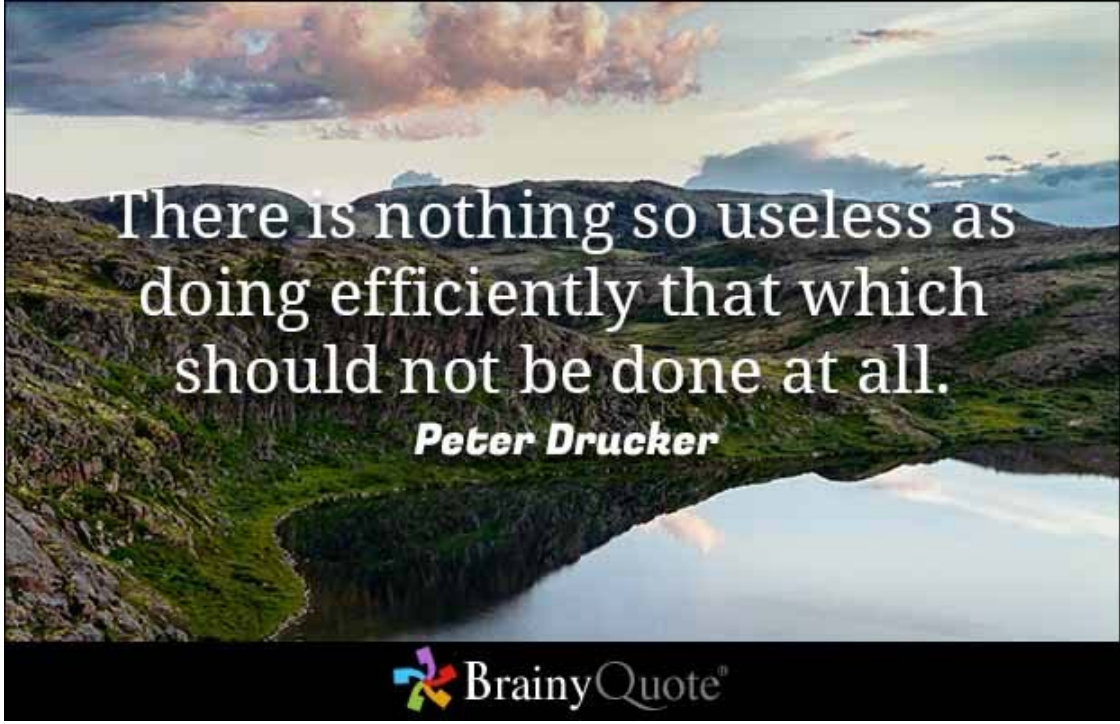
Shaping the Future…

- “Provincial planning will enable strategic decisions to be made across the entire health system, enabling long-term planning around education, staffing and recruitment and retention efforts, as well as investments in the supply chain, equipment and infrastructure,”
- “Best practices from across Canada and around the globe, combined with the experience and knowledge of Manitoba’s own clinical leaders, will ensure we are able to adapt to changing population needs and prioritize resources to ensure safe, accessible and consistent care for all Manitobans.”

Shared Health’s Mission

To build an accessible and integrated health system that *coordinates consistent and reliable care (QUALITY)*, capitalizes on talent and expertise across the province, demonstrates *positive outcomes (OUTCOMES)* and focuses *shared resources (COST)*to effectively serve the health needs of Manitobans.





- The primary barrier will be resistance to practice change.
- The biggest challenge will be communicating evidence-based, best-practices and following-through on uptake and adoption in regular clinical practice

Engaging Physicians More in Systems Transformation

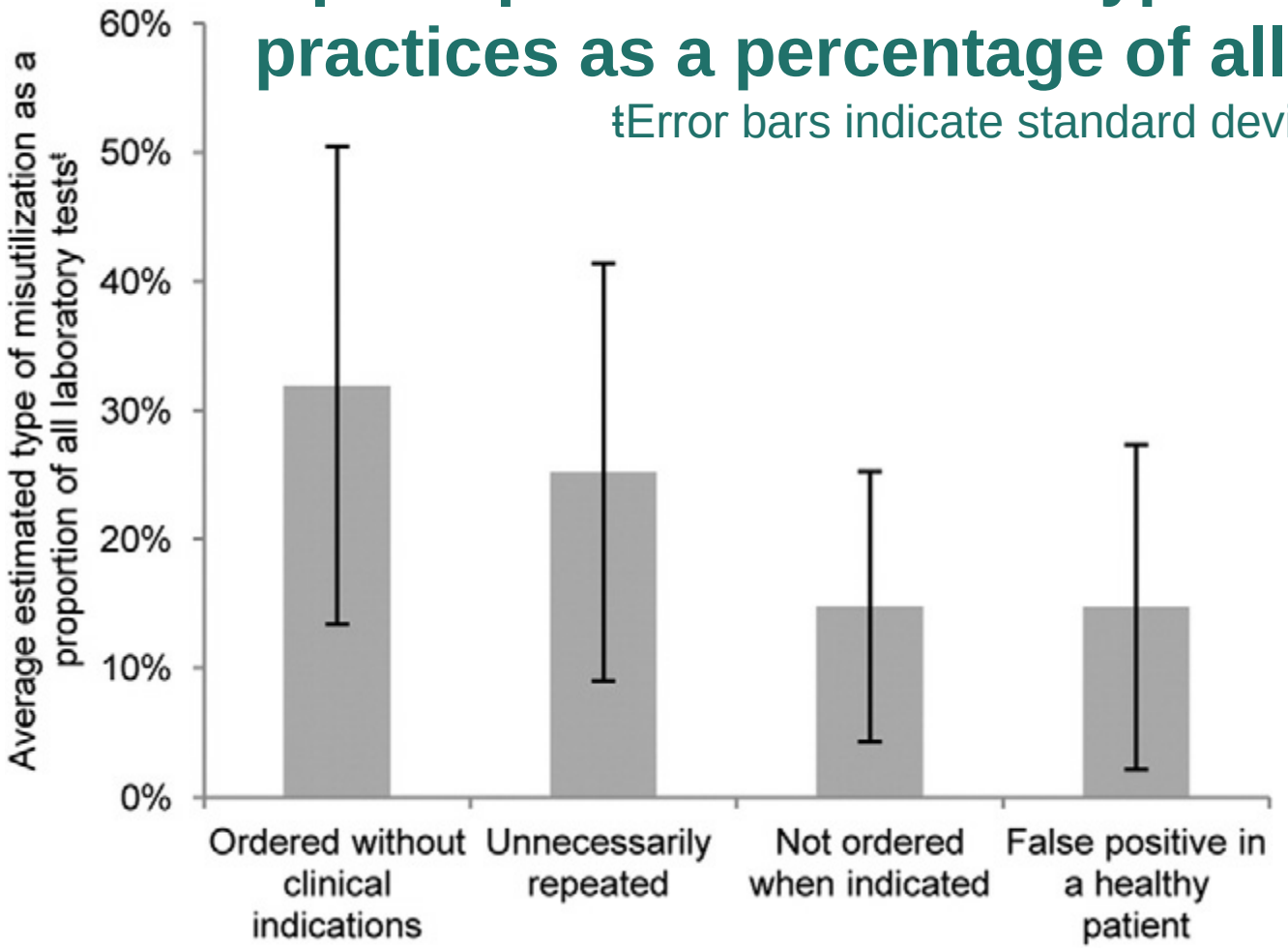
- Physicians are the key to any future renewal of the health sector in Canada.
- For physician engagement to occur, physicians need to be invited and to show up to meetings and other events, and to volunteer for projects.
- Physicians need to be trained to become leaders in our health care system.

We need to change the conversation

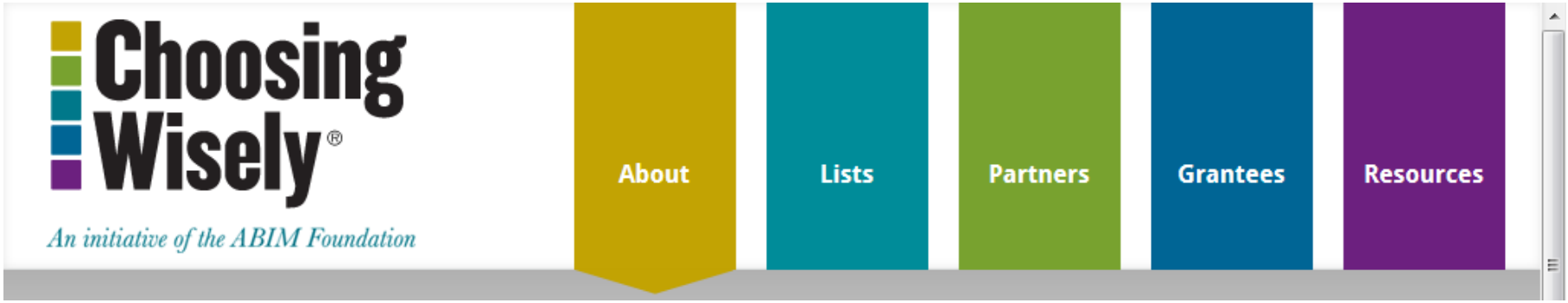
- **62%** of Canadians agree that there is a significant amount of unnecessary care in the health care system
- **92%** of Canadians believe patients need more support to know which services are really necessary for their health
- **68%** of Canadian family physicians agree that more tools are needed to help them make decisions about which services are inappropriate for their patients

Summary of Alberta family physicians perceptions of various types of lab testing practices as a percentage of all tests ordered.

ŧError bars indicate standard deviation.



Thommasen, A., Clement, F., Kinniburgh, David W., et al. Canadian family physician knowledge and attitudes toward laboratory utilization management, Clin Biochem, 2015 (49): 4-7.



Choosing Wisely aims 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

http://www.choosingwisely.org/
http://www.abimfoundation.org/

Choosing Wisely Canada

A national campaign to help physicians and patients engage in conversations about improving the appropriate use of diagnostic tests, treatments and procedures.

http://www.choosingwiselycanada.org/

When it comes to your health sometimes LESS is more

When it comes to your health, more medical tests, treatments and procedures are not always better. In fact, sometimes they are unnecessary and could do more harm than good.

Next time you see your doctor, have a conversation.

Do I really need this test, treatment or procedure?

Tests should help you and your doctor decide how to treat your problem, and treatments and procedures should help you live a longer, healthier life.

What are the downsides?

Discuss the risks as well as the chance of inaccurate results or findings that will never cause symptoms but may require further testing. Weigh the potential complications against possible benefits and the symptoms of the condition itself.

What happens if I do nothing?

Ask your doctor if your condition could get worse — or get better — if you don't have the test, treatment or procedure now.

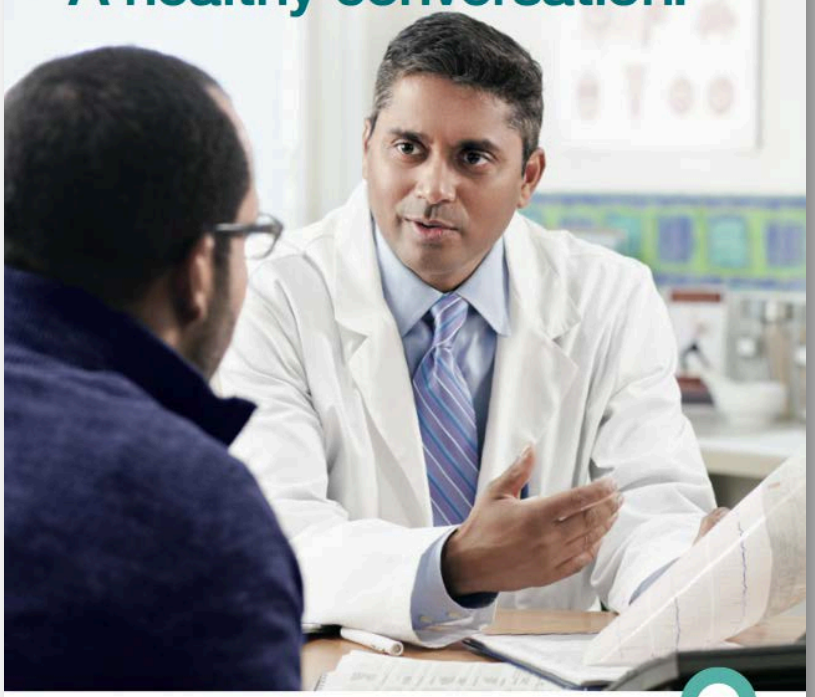
Are there simpler, safer options?

Sometimes lifestyle changes will provide all the relief you need.

ChoosingWiselyCanada.org
@ChooseWiselyCA

Choosing Wisely Canada
In partnership with the Canadian Medical Association

Choosing Wisely Canada.
A healthy conversation.



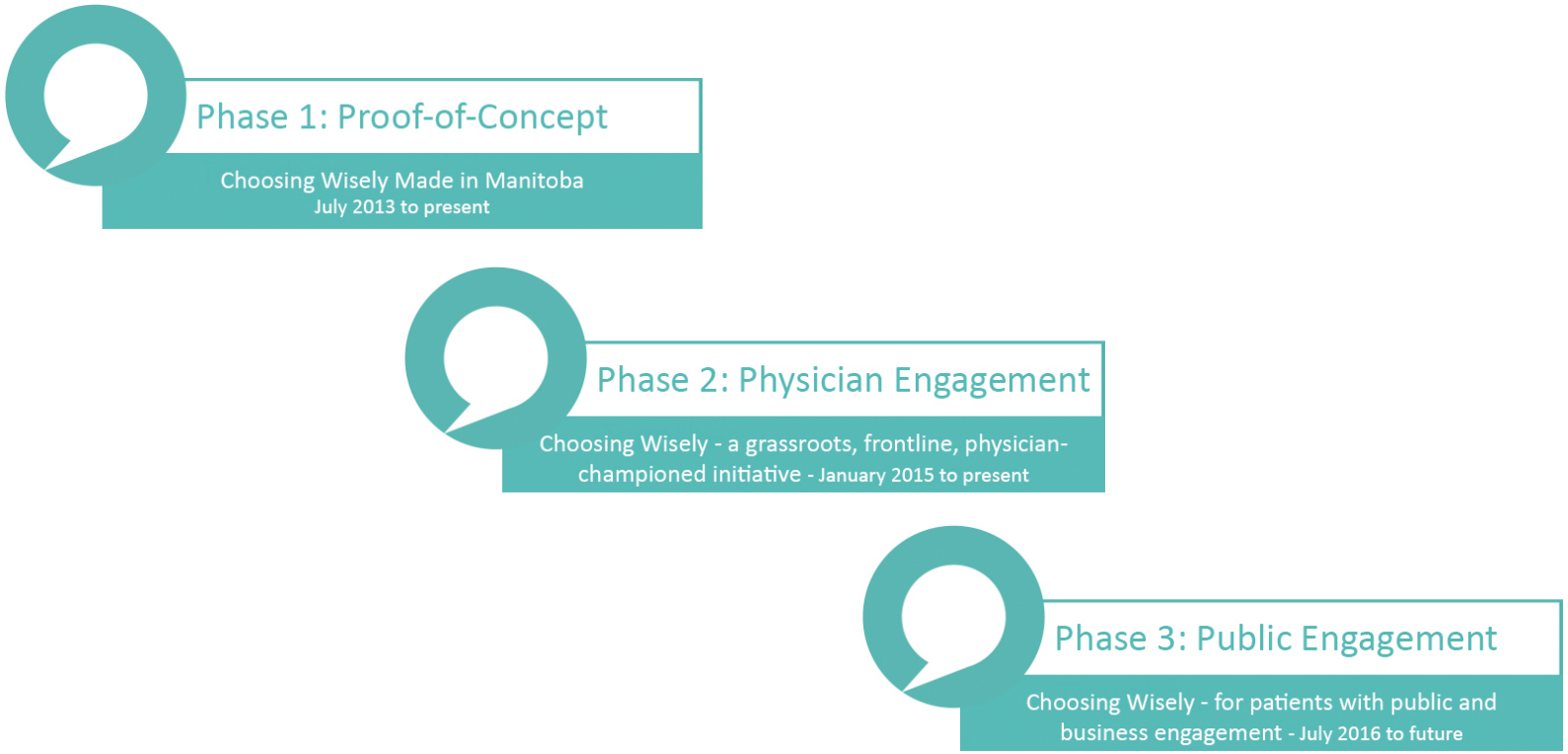
When it comes to your health, more medical tests, treatments and procedures are not always better. In fact, sometimes they're unnecessary. Find out when you need medical tests, treatments and procedures — and when you don't.

Talk with your doctor or visit ChoosingWiselyCanada.org

@ChooseWiselyCA

Choosing Wisely Canada
In partnership with the Canadian Medical Association

What is Choosing Wisely Manitoba?



Providing quality care:

doing the right thing for Manitobans and delivering value for money

WIIFM

We can embrace the opportunity to continue our own education, prepare ourselves for the future, review our services, and lead our own practice and system change

OR

We can react to changes that will occur and allow others to lead the change in our business and profession, and be victims of those changes to our careers and personal lives.

"Clayton Christensen has done it again, writing yet another book full of valuable insights . . . *The Innovator's Prescription* might just mark the beginning of a new era in healthcare."
—MICHAEL BLOOMBERG, Mayor, New York City

The Innovator's Prescription

A Disruptive Solution for Health Care

Clayton M. Christensen
BESTSELLING AUTHOR OF *THE INNOVATOR'S DILEMMA*
Jerome H. Grossman, M.D. & Jason Hwang, M.D.

Creating Ripples – Avoiding Waves
Data; Evidence; Debate

Choosing Wisely Manitoba

Seeing Lower Back Pain Clearly

Do you really need an MRI (or X-ray or CT scan) to speed up your recovery from lower back pain?

Muscle strains are the most common cause of lower back pain. Although the pain can be excruciating, the cause likely isn't serious. Though you may want to try everything possible to relieve the pain, research shows that diagnostic imaging procedures do not help you get better faster. Most people with lower back pain feel better in about a month whether they have an imaging test or not.

WHAT YOU CAN DO

- **Apply Heat or Cold** — use what feels best for you
- **Stay Active**
- **Sleep Comfortably** — on your side with the support of a pillow between your legs
- **Take Pain Medication**

On the other hand, having tests and procedures you don't need can lead to more unnecessary tests and in some cases even unnecessary surgery.

Openly and honestly discussing your symptoms, medical history and worries with your doctor is the best way to determine the right course of treatment for you.

Your doctor is providing the best care by not ordering unneeded tests. For lower back pain, MRI and other imaging tests are most often not the right choice.

See back for information on when an MRI may be right for your care

If pain continues and you have any of the following conditions, symptoms or medical history, call your doctor right away so he or she can reassess your care.

SERIOUS CONDITIONS, SYMPTOMS AND MEDICAL HISTORY

- Signs of severe or worsening nerve damage, including numbness, tingling, pricking sensations or muscle weakness
- A serious existing condition such as cancer or a spinal infection
- 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 you don't have the symptoms, conditions or medical history listed above, you probably don't need an MRI - at least not right away. Try the self-care measures listed on the front and let your doctor know of any changes or if pain lasts for more than a month.

This information is based on recommendations from the Canadian Association of Radiologists. It is not a substitute for medical advice.

Choosing Wisely Manitoba

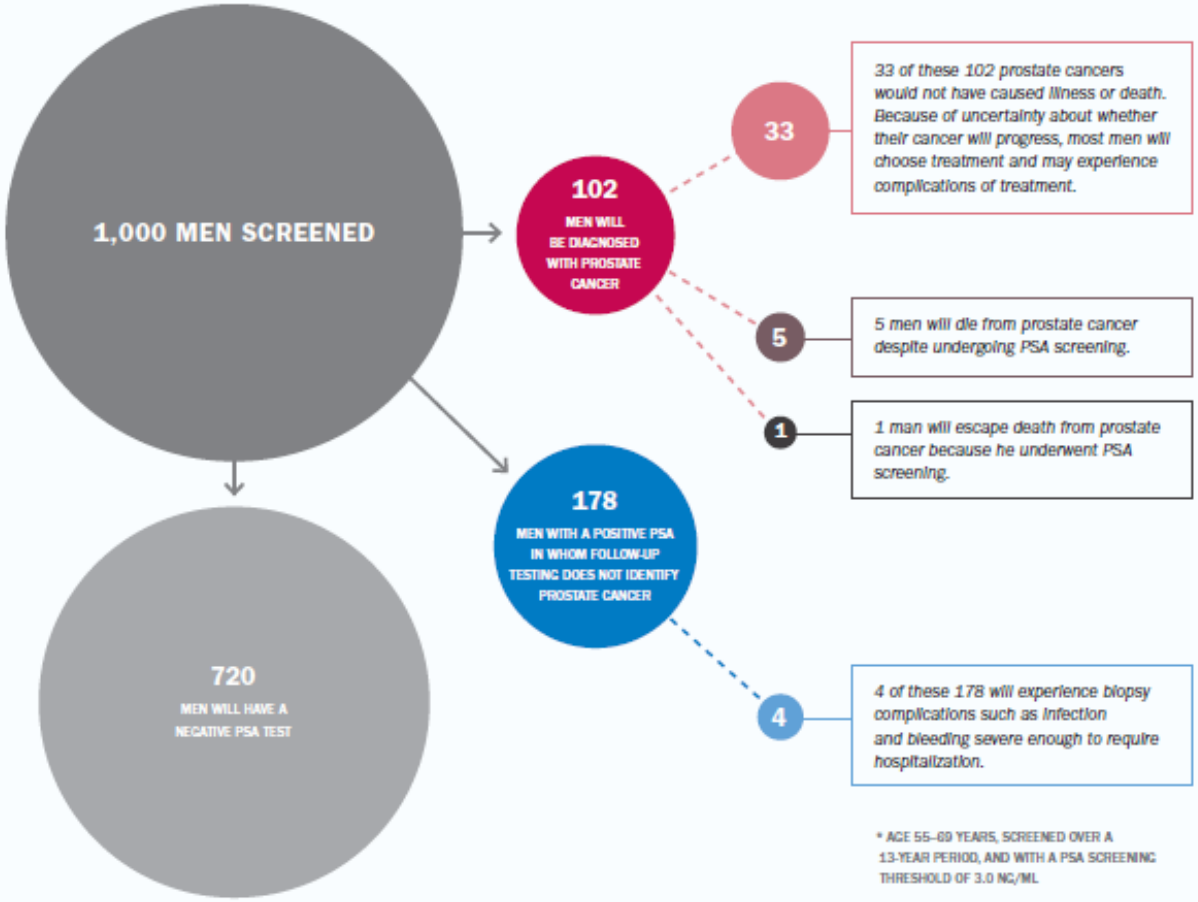
Choosing Wisely Manitoba is an initiative to improve health outcomes, patient and provider experiences and health system efficiencies and sustainability through the appropriate use of medical treatments and diagnostic testing.

Prostate Cancer

THE HARMS OF SCREENING GREATLY OUTWEIGH THE BENEFITS

Canadian Task Force on Preventive Health Care

RESULTS OF SCREENING 1,000 MEN WITH THE PSA TEST*



* AGE 55–69 YEARS, SCREENED OVER A 13-YEAR PERIOD, AND WITH A PSA SCREENING THRESHOLD OF 3.0 NG/ML

WHAT ARE MY RISKS IF I DON'T GET SCREENED?

- Among men ages 55 to 69 who do not get screened, the risk of dying from prostate cancer is 6 in 1,000.
- With regular PSA screening, the risk of dying from prostate cancer among men aged 55 to 69 may be reduced to 5 in 1,000.
- In many cases prostate cancer does not, and will not, pose a threat to a man's life.

ISN'T IT BETTER TO GET SCREENED THAN TO DO NOTHING?

- Screening with the PSA often leads to further testing, which carries with it its own serious risks and problems.
- For example, a biopsy involves a number of potential harms such as infection, blood in the urine, or even death.
- Additionally, if testing leads to treatment, such as a prostectomy (removal of the prostate gland), the chances of urinary incontinence and erectile dysfunction significantly increase. Other short term post-surgical complications include infections, additional surgeries and blood transfusions and death.

WHAT DOES THE CANADIAN TASK FORCE ON PREVENTIVE HEALTH CARE RECOMMEND?

- Based on the lack of convincing evidence that PSA screening reduces prostate cancer mortality, and based on the consistent evidence that screening and active treatment does lead to harm, the CTFPHC recommends not using PSA testing to screen for prostate cancer.
- For more information on the Canadian Task Force on Preventive Health Care's recommendations please visit: www.canadiantaskforce.ca.

WHAT ARE THE BENEFITS OF SCREENING?

- Reduced risk of dying from prostate cancer—1 out of every 1000 men will escape death because he underwent PSA screening.

INFO@CANADIANTASKFORCE.CA | WWW.CANADIANTASKFORCE.CA

Statistics for benefits and harms were calculated from the European Randomized Study of Screening for Prostate Cancer (ERSPC).

Canadian Task Force
on Preventive Health Care

PSA Screening: Primary Care Practitioner FAQ

The recommendations apply to all men not previously diagnosed with prostate cancer

- For men aged less than 55 years, we recommend not screening for prostate cancer with the prostate-specific antigen test.
  (Strong recommendation; low quality evidence)*
- For men aged 55-69 years, we recommend not screening for prostate cancer with the prostate-specific antigen test.
  (Weak recommendation; moderate quality evidence)
- For men 70 years of age and older, we recommend not screening for prostate cancer with the prostate-specific antigen test.
  (Strong recommendation; low quality evidence).

1. Why are there different recommendations for different age groups?

   There is no evidence that PSA screening reduces overall mortality for men of any age and consistent evidence that screening and active treatment lead to harm. However there is conflicting evidence suggesting a small and very uncertain potential reduction in prostate cancer mortality in men aged 55-69 years and no convincing evidence of a reduction in prostate cancer mortality for any other age group.

2. Do these guidelines include high-risk groups such as those of black race/ancestry or those with a family history of prostate cancer?

   Yes. There was no evidence indicating that men of black race/ancestry or those with a family history of prostate cancer (one or more affected first-degree relatives) should be screened differently from the average-risk population.

3. Does this guideline include screening with digital rectal examination (DRE)?

   This guideline recommends not screening with the PSA test, regardless of whether DRE is performed. Although DRE has been used in clinical practice to screen for prostate cancer, there was no evidence showing that DRE reduces prostate cancer mortality when used on its own or with the PSA test.

4. Is it necessary for primary care practitioners to discuss the benefits and harms of screening with their patients?

   If patients raise the issue of PSA screening, physicians should discuss the benefits and harms associated with screening. Men should understand that undergoing a PSA test can lead to additional testing if the PSA level is raised. Tools outlining the harms and benefits of screening are available at www.canadiantaskforce.ca

5. Why does the CTFPHC recommend against prostate cancer screening when the death rate has fallen since the introduction of the PSA test?

   There is no conclusive evidence to indicate what proportion of the decline in prostate cancer mortality is due to screening, improved treatment, or other factors; it is likely that both screening and treatment have contributed.

   However, the CTFPHC found that the potential small benefit that can result from PSA screening is outweighed by potential significant harms of PSA screening and associated follow-up treatment.

KEY POINTS

- The prevalence of undiagnosed prostate cancer at autopsy is high and increases with age (over 40% in men aged 40-49 years to over 70% in men aged 70 to 79 years).
- Only a small proportion of prostate cancer causes symptomatic disease or death whereas the majority is slowly progressive and not life threatening.
- Screening with PSA may lead to a small reduction in prostate cancer mortality but does not reduce overall mortality.
- PSA thresholds of 2.5ng/ml to 4.0ng/ml are commonly used for screening, with lower thresholds increasing the probability of false positive results and overdiagnosis, but no value completely excludes prostate cancer.
- Harms (such as bleeding, infection, urinary incontinence, false positives and overdiagnosis) are common following PSA screening.
- PSA should not be used for screening without prior informed discussion, ideally using decision aids to facilitate comprehension.

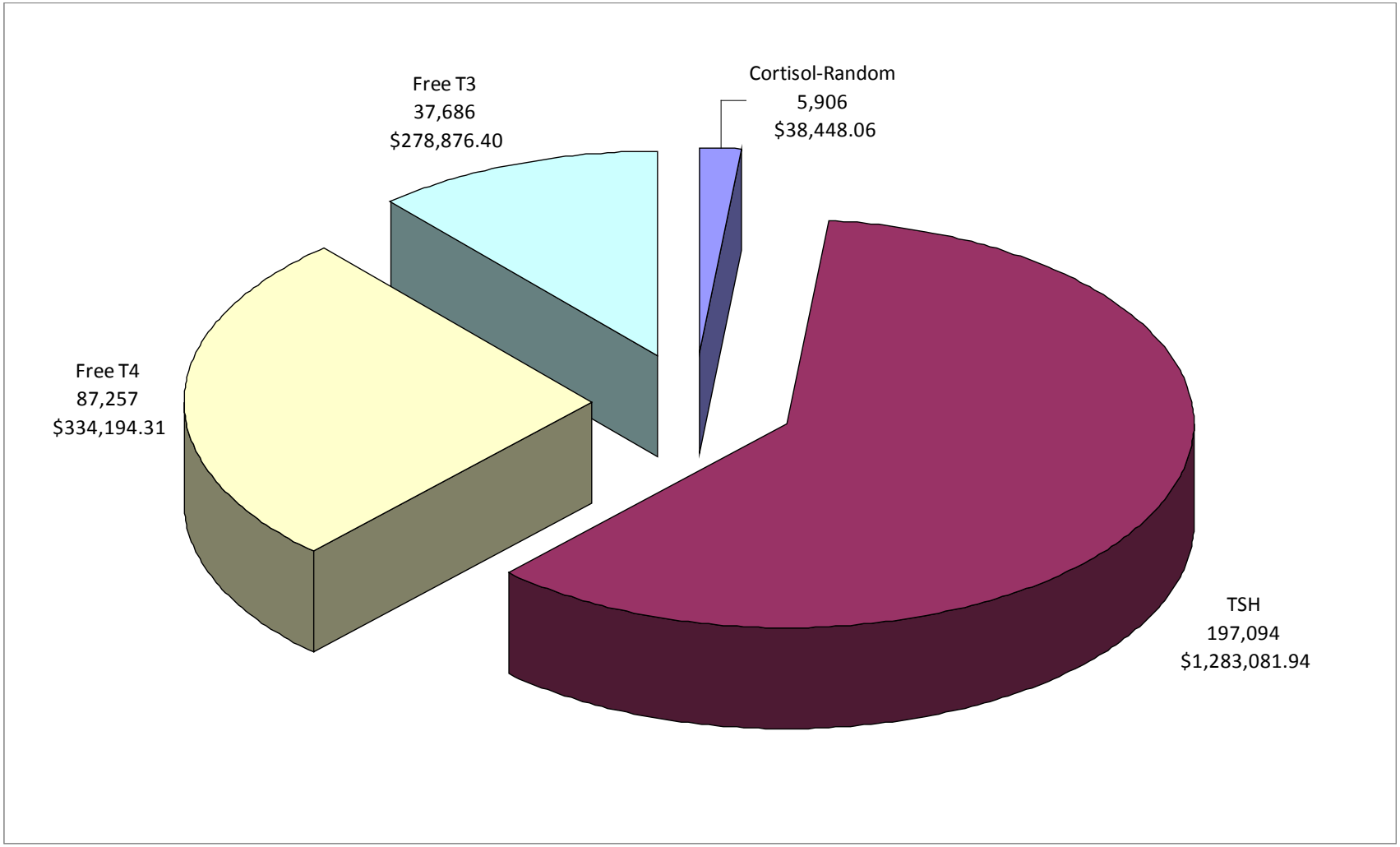
*Recommendations are graded according to the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. For explanations of GRADE recommendations, please see: www.canadiantaskforce.ca/methods/grade/

American Society for Clinical Pathology

Don’t order multiple tests in the initial evaluation of a patient with suspected non-neoplastic thyroid disease. Order thyroid-stimulating hormone (TSH), and if abnormal, follow up with additional evaluation or treatment depending on the findings.

The TSH test can detect subclinical thyroid disease in patients without symptoms of thyroid dysfunction. A TSH value within the reference interval excludes the majority of cases of primary overt thyroid disease. If the TSH is abnormal, confirm the diagnosis with free thyroxine (T4).

High Volume Hormones (2016)
Test Volumes: 327,943 Test Costs: $1,934,600.71



CSEM SCEM
The Canadian Society of Endocrinology and Metabolism
La Société canadienne d'endocrinologie et de métabolisme

Don't routinely order a thyroid ultrasound in patients with abnormal thyroid function tests unless there is a palpable abnormality of the thyroid gland.

Thyroid ultrasound is used to identify and characterize thyroid nodules, and is not part of the routine evaluation of abnormal thyroid function tests (over- or underactive thyroid function) unless the patient also has a large goiter or a lumpy thyroid. Incidentally discovered thyroid nodules are common. Overzealous use of ultrasound will frequently identify nodules, which are unrelated to the abnormal thyroid function, and may divert the clinical evaluation to assess the nodules, rather than the thyroid dysfunction. Imaging may be needed in thyrotoxic patients; when needed, a thyroid scan, not an ultrasound, is used to assess the etiology of the thyrotoxicosis and the possibility of focal autonomy in a thyroid nodule.

Don't use Free T4 or T3 to screen for hypothyroidism or to monitor and adjust levothyroxine (T4) dose in patients with known primary hypothyroidism.

T4 is converted into T3 at the cellular level in virtually all organs. Intracellular T3 levels regulate pituitary secretion and blood levels of TSH, as well as the effects of thyroid hormone in multiple organs. Therefore, in most people a normal TSH indicates either normal endogenous thyroid function or an adequate T4 replacement dose. TSH only becomes unreliable in patients with suspected or known pituitary or hypothalamic disease when TSH cannot respond physiologically to altered levels of T4 or T3.

Don't routinely test for Anti-Thyroid Peroxidase Antibodies (anti – TPO).

Positive anti-TPO titres are not unusual in the 'normal' population. Their presence in the context of thyroid disease only assists in indicating that the pathogenesis is probably autoimmune. As thyroid autoimmunity is a chronic condition, once diagnosed there is rarely a need to re-measure anti-TPO titres. In euthyroid pregnant patients deemed at high risk of developing thyroid disease, anti-TPO antibodies may influence the frequency of surveillance for hypothyroidism during the pregnancy. It is uncommon that measurement of anti-TPO antibodies influences patient management.

SOCIETY OF NUCLEAR MEDICINE AND MOLECULAR IMAGING

Don’t use nuclear medicine thyroid scans to evaluate thyroid nodules in patients with normal thyroid gland function.

Nuclear medicine thyroid scanning does not conclusively determine whether thyroid nodules are benign or malignant.

- Cold nodules on thyroid scans will still require biopsy.
- Nuclear medicine thyroid scans are useful to evaluate the functional status of thyroid nodules in patients who are hyperthyroid.

CANM ACMN
THE CANADIAN ASSOCIATION OF NUCLEAR MEDICINE
L’ASSOCIATION CANADIENNE DE MÉDECINE NUCLÉAIRE

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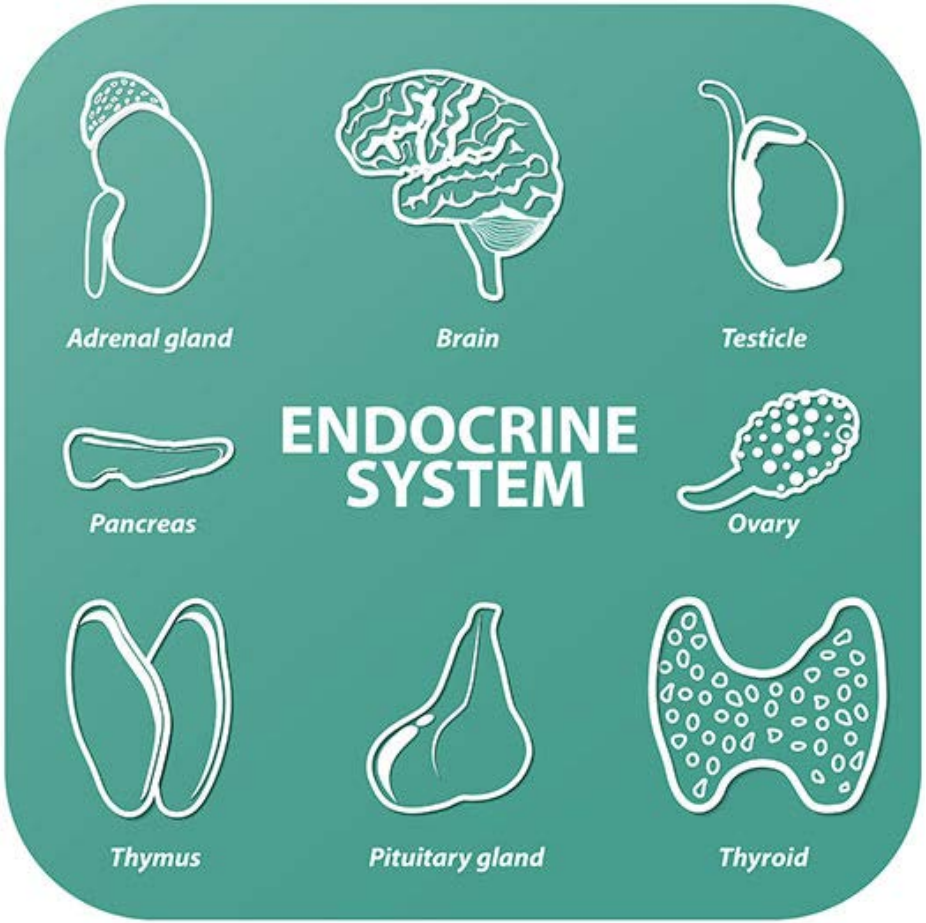
We’re just getting starter…!!!



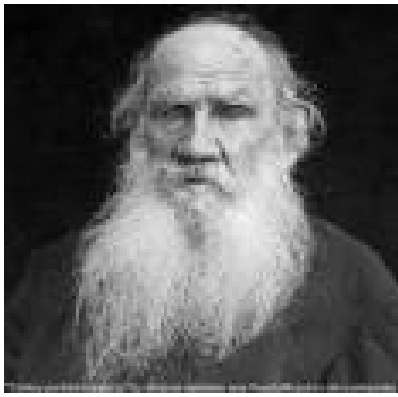
- Testosterone
- Aldosterone
- Cortisol
- 18-Hydroxycortisol
- DHEA-S
- Growth hormone (GH),
- Insulin-like growth factor-1 (IGF-1)
- Prolactin
- ACTH
- Luteinizing hormone (LH),
- Follicle-stimulating hormone (FSH)
- CA125
- Alpha feta protein (AFP)
- Human chorionic gonadotropin (HCG)
- Lactate dehydrogenase (LDH)
- Amylase
- Lipase

Choosing Wisely – Pediatric Laboratory 1-11

1. *Don't perform screening panels (IgE tests) for food allergies without previous consideration of the pertinent medical history.*
2. *Don't routinely do a throat swab when children present with a sore throat if they have a cough, rhinitis, or hoarseness as they almost certainly have viral pharyngitis.*
3. *Don't order C-reactive protein (CRP) levels in children with suspected appendicitis.*
4. *Don't delay testing for total and conjugated (direct) bilirubin in any newborn with persistent jaundice beyond 2 weeks of age.*
5. Don't perform voiding cystourethrogram (VCUG) routinely in first febrile urinary tract infection (UTI) in children aged 2 -24 months.
6. Avoid the use of surveillance cultures for the screening and treatment of asymptomatic bacteriuria.
7. Don't perform screening panels for food allergies without previous consideration of medical history.
8. Don't repeat a confirmed positive ANA in patients with established JIA or systemic lupus erythematosus (SLE).
9. Don't perform methotrexate toxicity labs more often than every 12 weeks on stable doses.
10. Don't test for Lyme disease as a cause of musculoskeletal symptoms without an exposure history and appropriate exam findings.
11. Don't order autoantibody panels unless positive antinuclear antibodies (ANA) and evidence of rheumatic disease.

"Everyone thinks of changing the world, but no one thinks of changing himself."

Leo Tolstoy



Key points

- Two thirds of common laboratory investigations ordered during hospitalisation of patients did not influence management decisions.
- Factors in the case profile independently associated with overuse of diagnostic tests included prolonged stay in hospital, increased age and unfavourable outcome or inability to establish the diagnosis.
- Redundant ordering of tests occurred less often for haematology investigations compared with biochemistry; examination of arterial blood gas was least often overused test.
- Trainees had a low and disparate level of awareness about the cost of laboratory examinations that they order routinely.
- An intervention including audit, education and alertness of doctors, which was based on assessment of factors contributing to laboratory overutilisation, resulted in a marked decrease in the unnecessary ordering of tests; however, this containment gradually waned during the semester after intervention.

Choosing Wisely – Pediatric Imaging 1-10

1. *Don't image a midline dimple related to the coccyx in an asymptomatic infant or child.*
2. *Don't order a CT to initially investigate macrocephaly (order an ultrasound or MRI).*
3. *Don't use CT scans for routine imaging of children with hydrocephalus. Fast sequence non-sedated MRIs or ultrasounds provide adequate information to assess patients without exposing them to radiation or an anesthetic.*
4. *Don't do routine surveillance imaging for incidentally discovered Chiari I malformation.*
5. *Don't do computed tomography (CT) for the evaluation of suspected appendicitis in children until after ultrasound has been considered as an option.*
6. *Don't order CT head scans in adults and children who have suffered minor head injuries (unless positive for a validated head injury clinical decision rule).*
7. *Don't order a routine ultrasound for umbilical and/or inguinal hernia.*
8. *Don't do computed tomography (CT) for the evaluation of suspected appendicitis in children until after ultrasound has been considered as an option.*
9. *Don't order a routine ultrasound for children with undescended testes.*
10. *Don't routinely use computed tomography (CT) to screen pediatric patients with suspected nephrolithiasis.*

Choosing Wisely – Pediatric Practices 1-7

1. Don’t order orthotics for asymptomatic children with pes planus (flat feet).
2. Don’t recommend helmets for mild to severe positional flattening.
3. Don’t miss the opportunity to initiate conversations with patients about whether a test, treatment or procedure is necessary.
4. Don’t automatically initiate continuous electronic fetal heart rate (FHR) monitoring during labor for women without risk factors; consider intermittent auscultation (IA) first.
5. Don’t place ear tubes in otherwise healthy children who have had a single episode of ear fluid lasting less than 3 months.
6. Don’t use continuous pulse oximetry routinely in children with acute respiratory illness unless they are on supplemental oxygen.
7. Don’t delay referral for undescended testes beyond 6 months of age.

Choosing Wisely – Pediatric Prescribing 1-10

1. *Don't use atypical antipsychotics as a first-line intervention for insomnia in children and youth.*
2. *Don't routinely use acid blockers or motility agents for the treatment of gastroesophageal reflux in infants.*
3. Don't administer psychostimulant medications to preschool children with Attention Deficit Disorder (ADD), but offer parent-administered behavioural therapy.
4. *Don't recommend the use of cough and cold remedies in children under six years of age.*
5. Don't prescribe antibiotics in adults with bronchitis/asthma and children with bronchiolitis.
6. *Don't use antibiotics in adults and children with uncomplicated sore throats.*
7. *Don't use antibiotics in adults and children with uncomplicated acute otitis media.*
8. Don't prescribe medication to treat childhood insomnia, which usually arises from parent-child interactions and responds to behavioral intervention.
9. Don't prescribe antibiotics for otitis media in children aged 2-12 years with non-severe symptoms where the observation option is reasonable.
10. Don't routinely use perioperative antibiotics for elective tonsillectomy in children.

Antibiotic resistance in numbers

25k

The number of people who die each year across Europe from infections resistant to antibiotics

A recent study showed that the likelihood of GPs prescribing antibiotics for coughs & colds increased by 40% between 1999-2011

40%

30 years

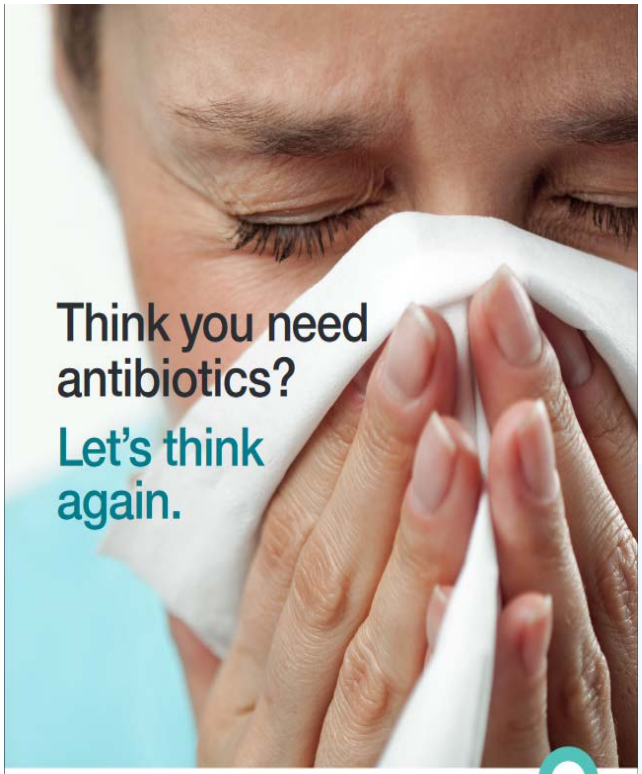
The period of time since a new class of antibiotics was last introduced despite the fact that growing numbers of infections are resistant to antibiotics

Research has shown that only 10% of sore throats and 20% of acute sinusitis benefit from antibiotic treatment but the prescription rates are much higher than this

10%

€1.5 billion

Annual EU wide cost of healthcare expenses and lost productivity due to antibiotic resistant bacteria



Think you need antibiotics?

Let's think again.

A healthy conversation about medical tests, treatments and procedures.

Talk with your doctor or visit ChoosingWiselyCanada.org

@ChooseWiselyCA

Choosing Wisely Canada

In partnership with the Canadian Medical Association

Rx

You have not been prescribed antibiotics because antibiotics are NOT effective in treating viral infections.

Antibiotics can cause side effects (e.g. diarrhea, yeast infections, rash) and should only be used when appropriate.

Southern Health Santé Sud

DIAGNOSIS

You have an illness that is most likely caused by a **VIRUS**. Note the estimated duration of illness by diagnosis, and that individual experiences differ.

☐ Upper Respiratory Tract Infection (Common Cold)	7-14 days
☐ Influenza (Flu)	7-14 days
☐ Acute Pharyngitis (Sore Throat)	3-10 days
☐ Acute Bronchitis/Chest Cold (Cough)	7-21 days
☐ Acute Sinusitis (Sinus Infection)	7-14 days

INSTRUCTIONS

- Rest as much as possible
- Drink plenty of fluids (water, juice)
- Wash your hands frequently
- Cover your mouth when you cough

The suggested treatments below may help you feel better while your body fights off the virus. Be sure to read and follow the instructions on the medication box.

- ☐ Acetaminophen
- ☐ Anti-inflammatory (e.g. Ibuprofen or naproxen)
- ☐ Sore throat lozenge (cough candy)
- ☐ Saline spray or rinse for nasal stuffiness
- ☐ Nasal decongestant
- ☐ Honey
- ☐ Other: _____

SEEK FURTHER HELP IF

- Your symptoms worsen at any time
- Your symptoms don't improve as expected
- You develop trouble breathing

Prescriber _____

Date _____

ChoosingWiselyManitoba

How do you define Value in Healthcare?

- **Safe**: Avoiding harm to patients from the care that is intended to help them.
- **Effective**: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered**: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely**: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status

Institute for Healthcare Improvement (IHI)

We are at cross roads

- Never a better time to stop doing those things that don’t add clinical value
- Never a better time to develop evidence based guidelines and lead the way
- Never a better time to save healthcare money while improving care
- Never had so much buy in from providers
- Choosing Wisely Manitoba – more support and ideas than resources to execute
- Collaboration – working together to lead our own practice changes

I don't order that test?

WILL I GET INTO TROUBLE?

Beyond Change Management: Changing Culture - Changing Outcomes

Engaging physicians is a key component to health system transformation in Manitoba.

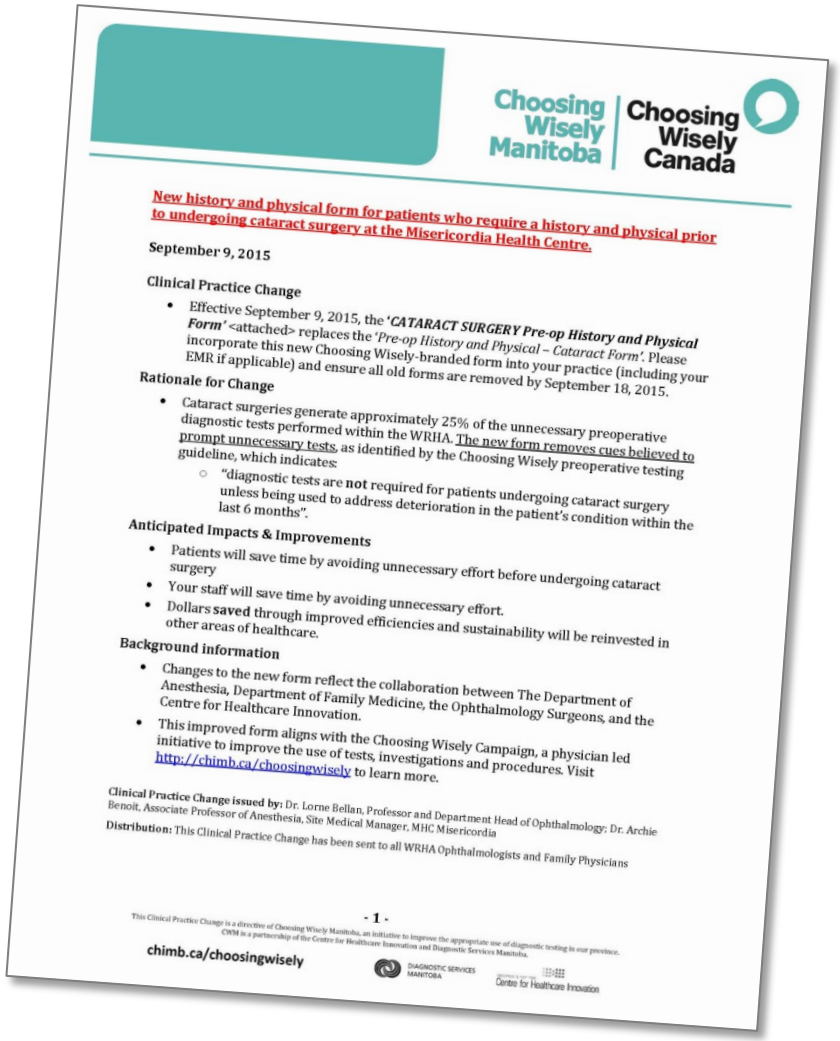
Clinician Role Conflict

- Am I doing my best for each and every patient?
- Am I ensuring sustainable resources to serve all patients across the system?

Are we adding clinical value?
How are we improving patient outcomes?

Clinical Practice Change

- Establishing a standard to communicate Clinical Practice Changes
- Awareness and Information
- Evidence and Data
- Performance, Audit, and Review
- Reinforce and ?



Choosing Wisely Manitoba | Choosing Wisely Canada

New history and physical form for patients who require a history and physical prior to undergoing cataract surgery at the Misericordia Health Centre.

September 9, 2015

Clinical Practice Change

- Effective September 9, 2015, the ***'CATARACT SURGERY Pre-op History and Physical Form'*** <attached> replaces the *'Pre-op History and Physical – Cataract Form'*. Please incorporate this new Choosing Wisely-branded form into your practice (including your EMR if applicable) and ensure all old forms are removed by September 18, 2015.

Rationale for Change

- Cataract surgeries generate approximately 25% of the unnecessary preoperative diagnostic tests performed within the WRHA. The new form removes cues believed to prompt unnecessary tests, as identified by the Choosing Wisely preoperative testing guideline, which indicates:
  - "diagnostic tests are **not** required for patients undergoing cataract surgery unless being used to address deterioration in the patient's condition within the last 6 months".

Anticipated Impacts & Improvements

- Patients will save time by avoiding unnecessary effort before undergoing cataract surgery
- Your staff will save time by avoiding unnecessary effort.
- Dollars **saved** through improved efficiencies and sustainability will be reinvested in other areas of healthcare.

Background information

- Changes to the new form reflect the collaboration between The Department of Anesthesia, Department of Family Medicine, the Ophthalmology Surgeons, and the Centre for Healthcare Innovation.
- This improved form aligns with the Choosing Wisely Campaign, a physician led initiative to improve the use of tests, investigations and procedures. Visit http://chimb.ca/choosingwisely to learn more.

Clinical Practice Change issued by: Dr. Lorne Bellan, Professor and Department Head of Ophthalmology; Dr. Archie Benoit, Associate Professor of Anesthesia, Site Medical Manager, MHC Misericordia

Distribution: This Clinical Practice Change has been sent to all WRHA Ophthalmologists and Family Physicians

- 1 -

This Clinical Practice Change is a directive of Choosing Wisely Manitoba, an initiative to improve the appropriate use of diagnostic testing in our province. CWM is a partnership of the Centre for Healthcare Innovation and Diagnostic Services Manitoba.

chimb.ca/choosingwisely

DIAGNOSTIC SERVICES MANITOBA

Centre for Healthcare Innovation

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

Choosing Wisely Manitoba | Choosing Wisely Canada

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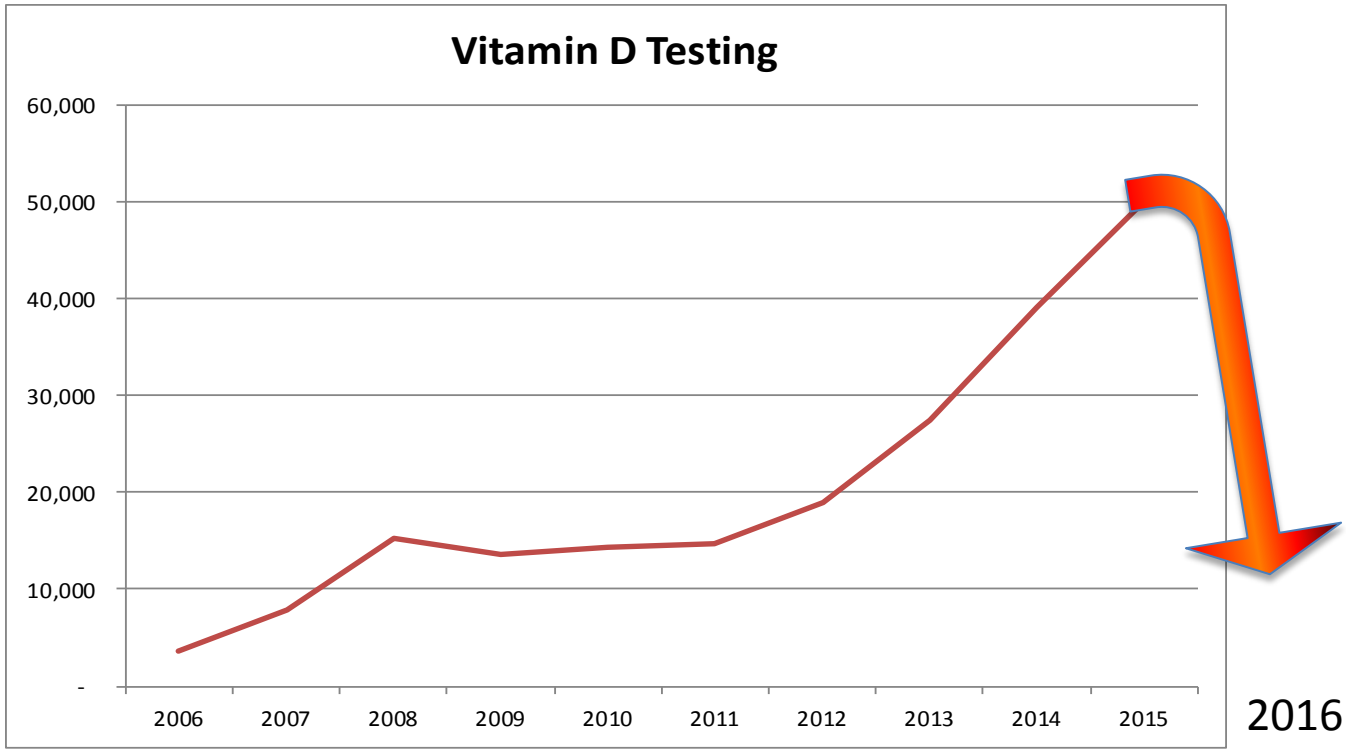
chimb.ca/choosingwisely

DIAGNOSTIC SERVICES MANITOBA

Centre for Healthcare Innovation

Vitamin D Testing



- 2015 volumes are estimated
- Vitamin D testing has increased by approx. 1,000% since 2006
- Approx. $800,000 annually on unnecessary Vit D tests

Preoperative Diagnostic testing

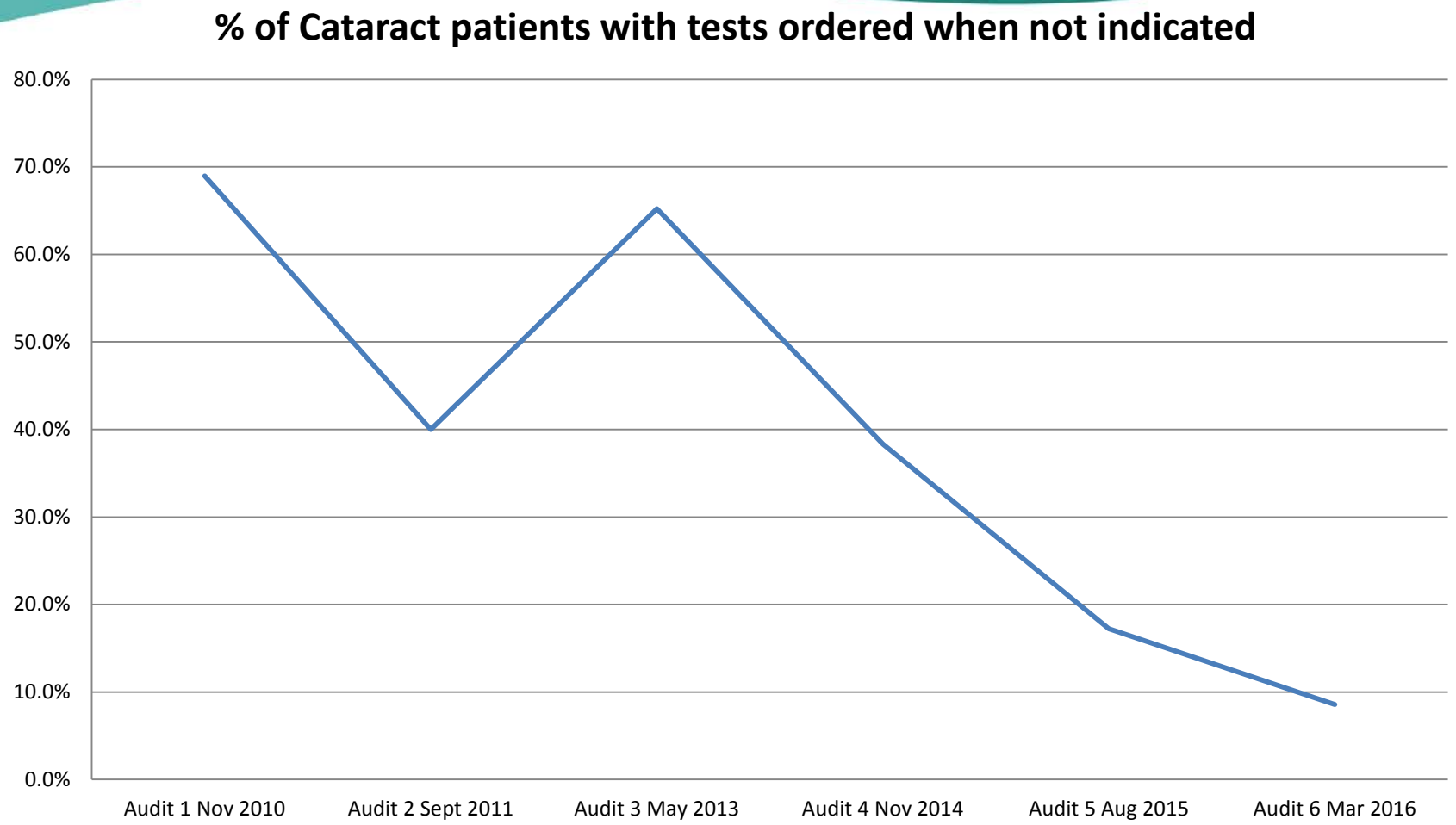
Test Name	$ / individual test	Test Not indictated and Ordered	Test Not indictated and Ordered (Phase 3 audit)	Test Not indictated and Ordered (annual estimate)	Annual $ Estimate	% of $
Chest X Ray	$ 28.55	66	$ 1,884.30	15,619	$ 445,916.11	21%
Liver Function Tests	$ 24.30	58	$ 1,409.40	13,726	$ 333,531.90	15%
ECG	$ 22.15	56	$ 1,240.40	13,252	$ 293,538.36	14%
Electrolytes	$ 19.00	62	$ 1,178.00	14,672	$ 278,771.52	13%
TSH	$ 19.30	30	$ 579.00	7,099	$ 137,019.28	6%
PTT	$ 9.12	62	$ 565.44	14,672	$ 133,810.33	6%
Creatinine	$ 8.65	63	$ 544.95	14,909	$ 128,961.41	6%
INR	$ 6.45	73	$ 470.85	17,275	$ 111,425.78	5%
Glucose	$ 4.95	88	$ 435.60	20,825	$ 103,083.93	5%
CBC	$ 5.95	73	$ 434.35	17,275	$ 102,788.12	5%
Iron indices	$ 16.15	20	$ 323.00	4,733	$ 76,437.35	4%
Urinalysis	$ 4.90	25	$ 122.50	5,916	$ 28,989.40	1%
Total		**676**	**$ 9,187.79**	**159,974**	**$ 2,174,273.49**	**100%**

62%

- 4 tests account for 62% of the dollars spent on tests not indicated and ordered

The results – Cataracts

Choosing Wisely Canada



Initiative	Benefits		
	Clinical Value*	Wait Times**	Financial ($)***

Cancer Wait Times/Delays:

- Breast: Direct Referral
- Breast: Pathology
- Colorectal: Pathology
- Lung: Pathology
- Gyne-Cervical: Pathology

Immunology:

Hematology:

- Coagulation:
- Bone Marrow Collections and processing (rural)
- Hematology:
- ESR: tube change
- Coag: tube change
- Cellavision: automated cell morphology and differential

Transfusion Medicine:

- Decreased blood and blood product wastage
- Trace Line reduced Crossmatch to Transfused ratio from 2.3 to 1.1
- Trace Line reduced TAT

Chemistry:

- Vitamin D Testing
- Serum Protein Analyzer (new technology)

Preoperative Diagnostics:

- Cervical Cancer Screening (Liquid Based Cytology vs PAP smears)

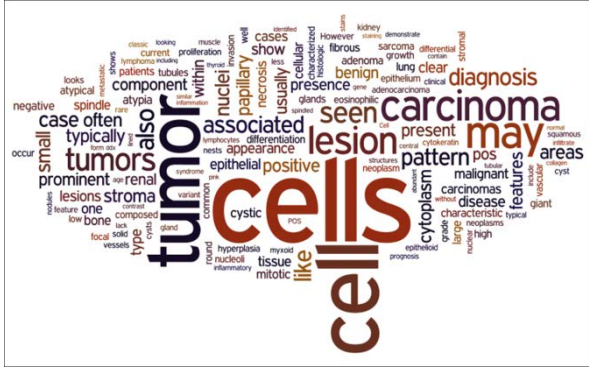
Microbiology:

- MALDI-TOF: automated culturing and identification
- Mycobacteriology Testing Standardization

Pathology:

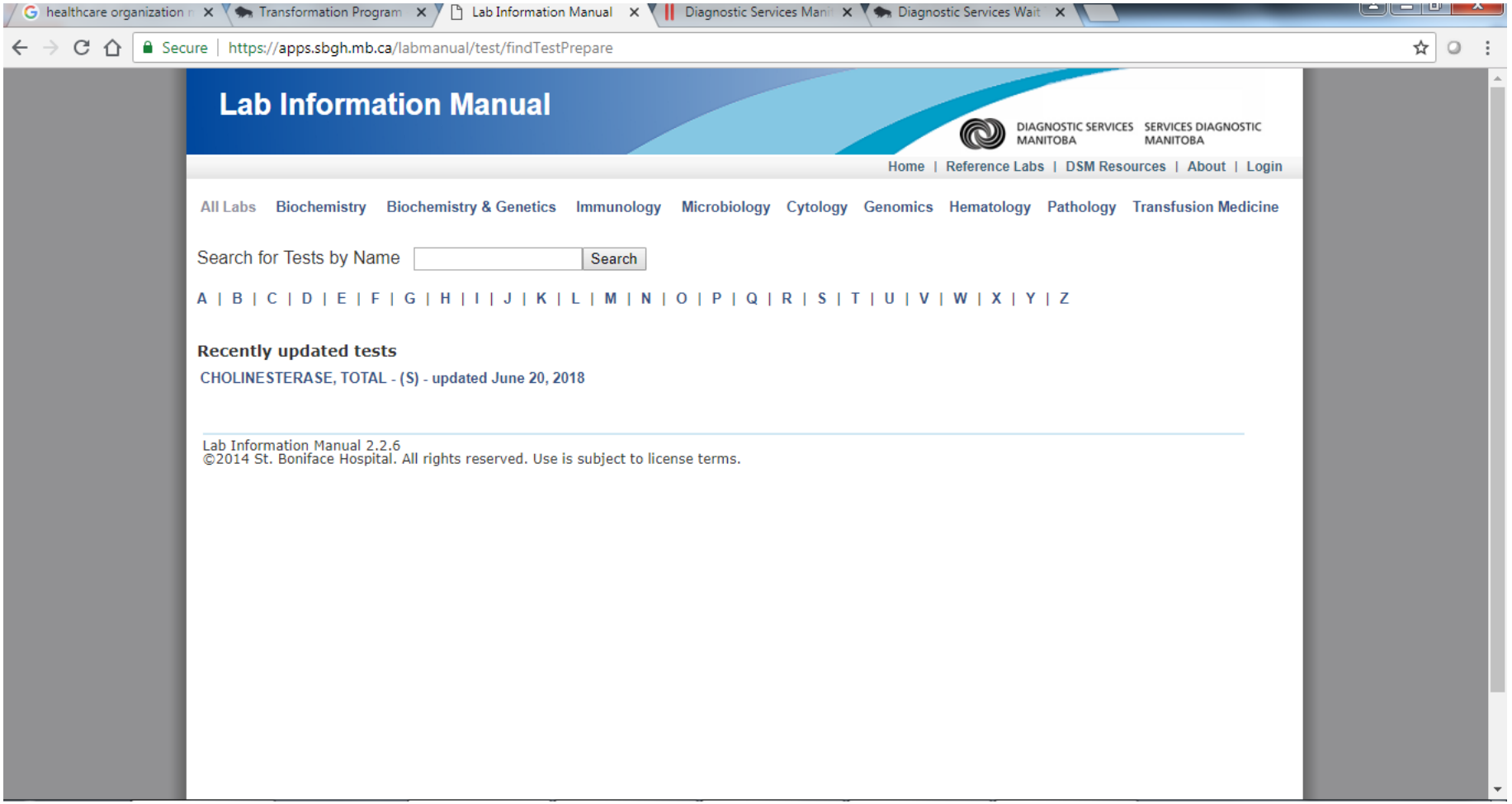
- Tissues for Disposal
- Cytotechnology

Pathology



- Hip & Knee Pathology - Tissues for Disposal
- Hospitals' Act
- Products of Conception
- Specimens for Peripheral Vascular Disease
- "Made in Manitoba" Provincial Standards for Tissue Disposal

- 98% reduction (<5 cases/month) within 1 year
- 78% reduction
- 63% reduction
- 90% reduction in pathologist microscopic examination
- ???


healthcare organization
Transformation Program
Lab Information Manual
Diagnostic Services Mani
Diagnostic Services Wait
Secure | https://apps.sbgh.mb.ca/labmanual/test/findTestPrepare
Lab Information Manual
DIAGNOSTIC SERVICES MANITOBA
SERVICES DIAGNOSTIC MANITOBA
Home | Reference Labs | DSM Resources | About | Login
All Labs Biochemistry Biochemistry & Genetics Immunology Microbiology Cytology Genomics Hematology Pathology Transfusion Medicine
Search for Tests by Name
Search
A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z
Recently updated tests
CHOLINESTERASE, TOTAL - (S) - updated June 20, 2018
Lab Information Manual 2.2.6
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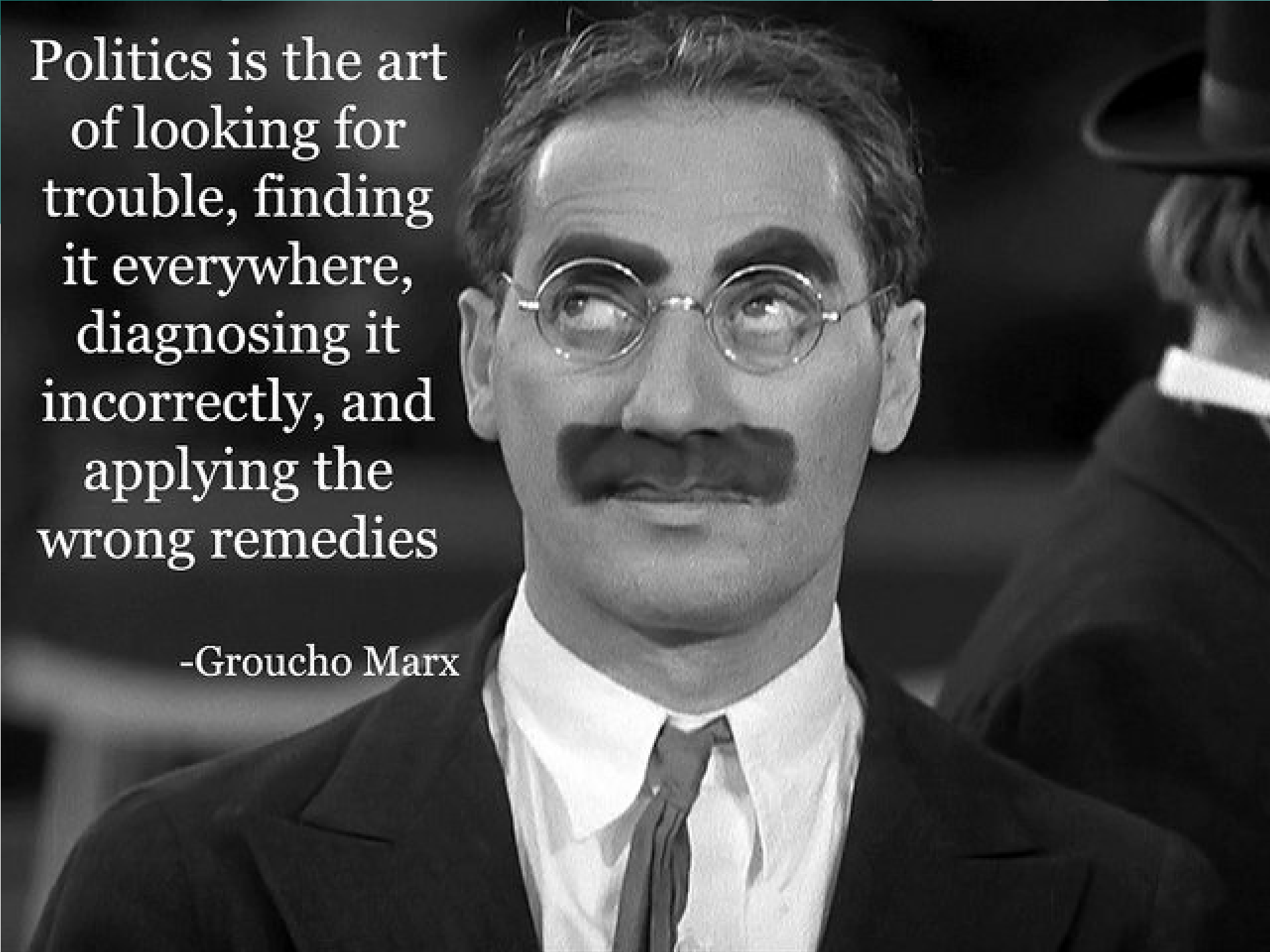
Become a Clinical Champion

What is your favourite CW recommendation?
What is your appropriateness (inappropriate) pet peeve?


Politics is the art of looking for trouble, finding it everywhere, diagnosing it incorrectly, and applying the wrong remedies
-Groucho Marx

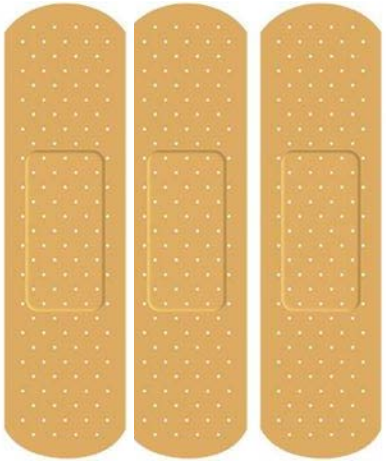
VBHC: the CQO Movement

- **Cost:** how value relates to the cost of services, products, supplies
- **Quality:** how value relates to the quality of patient care, the services provided, and the patient experience
- **Outcomes:** how value relates to improving patient outcomes (e.g. satisfaction, mobility, QALY, readmissions, “never events,” etc.)

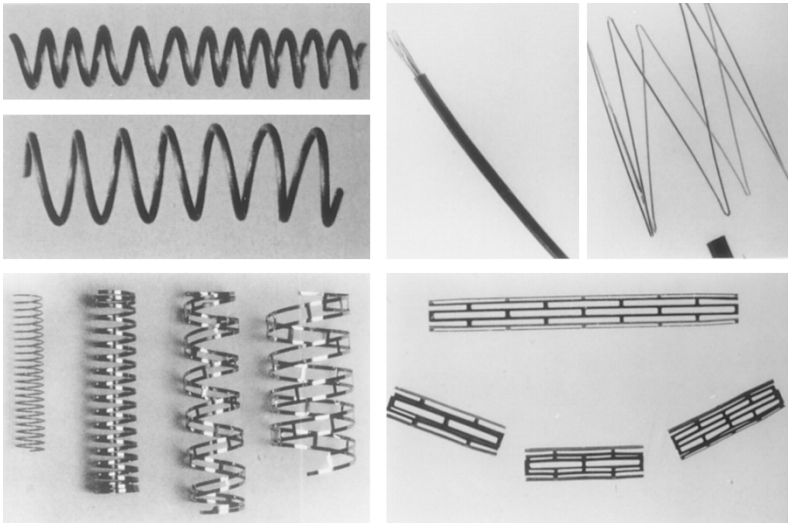
It is important to consider these relationships together rather than in separate silos.

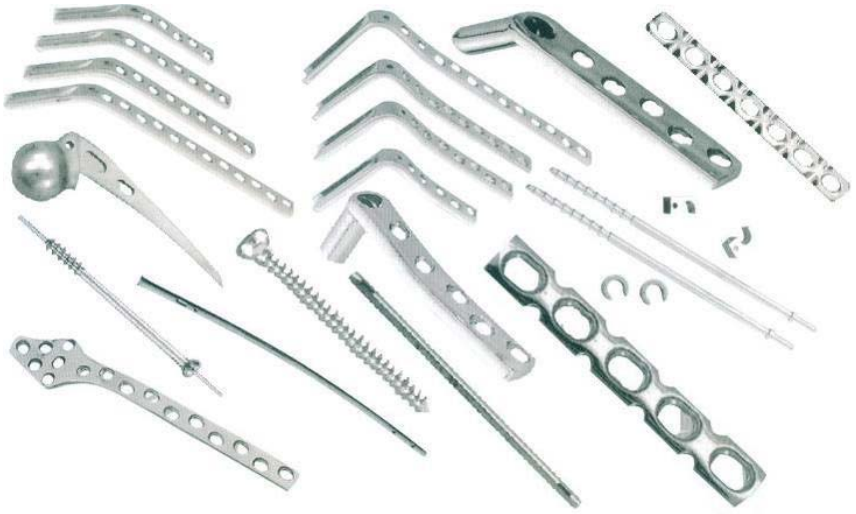
Value Based Health Care

Value-based care is simply the idea of improving quality and outcomes for patients. Reaching this goal is based on a set of changes in the ways a patient receives care. Overall wellness, quality of care, and preventive screenings all are key to bringing about better outcomes.

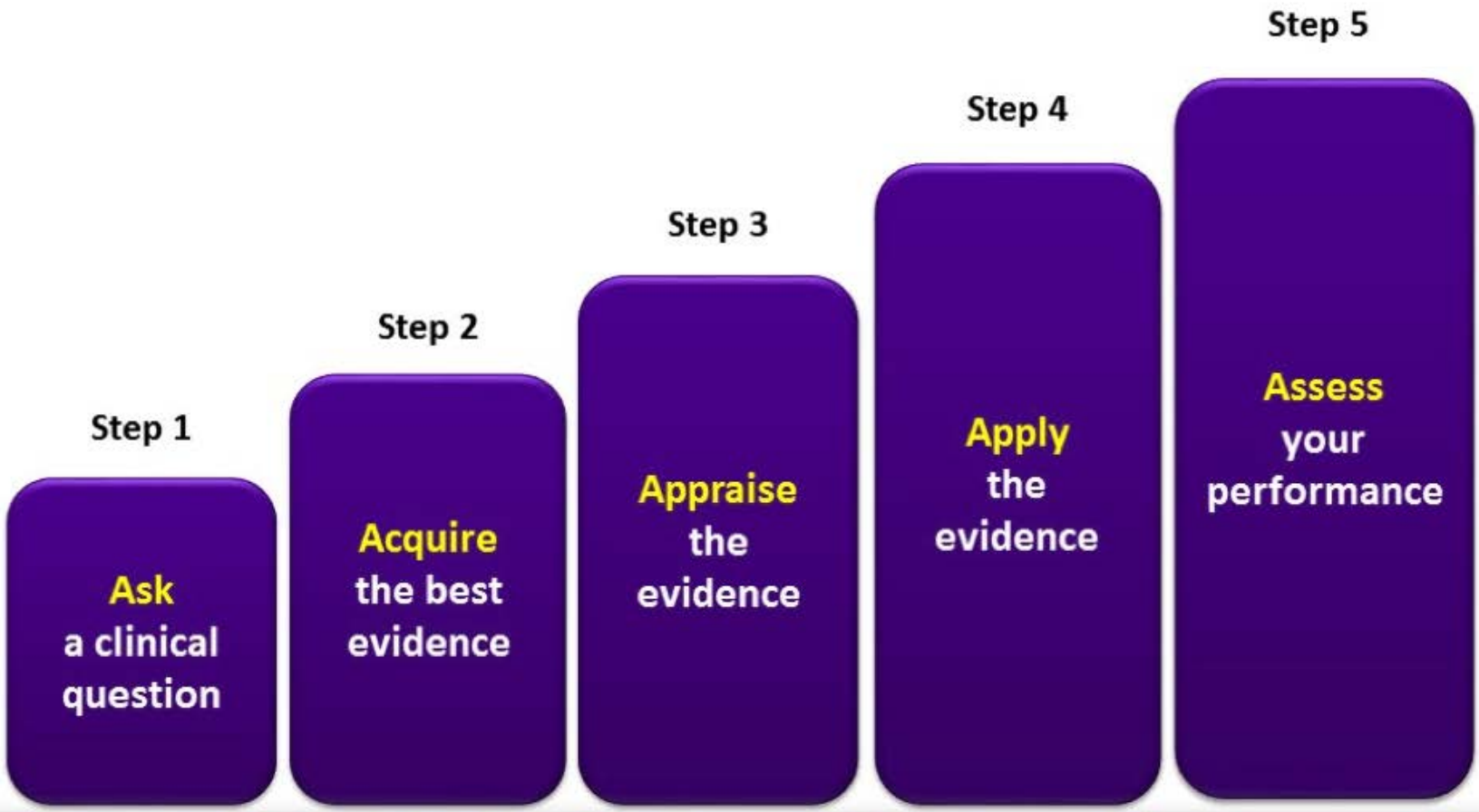


Total cost of "ownership" (full service costs)





The 5 Steps of Evidence-Based Medicine



Value Based Procurement

1. Procure a solution NOT a product
2. Focus on value and measurable outcomes, defined well beyond cost parameters and traditional procurement practices
3. Adhere to principles of Fair, Accountable, Transparent (competitive)
4. Make strategy drive innovation procurement

Dr Anne Snowden, Alberta Innovates

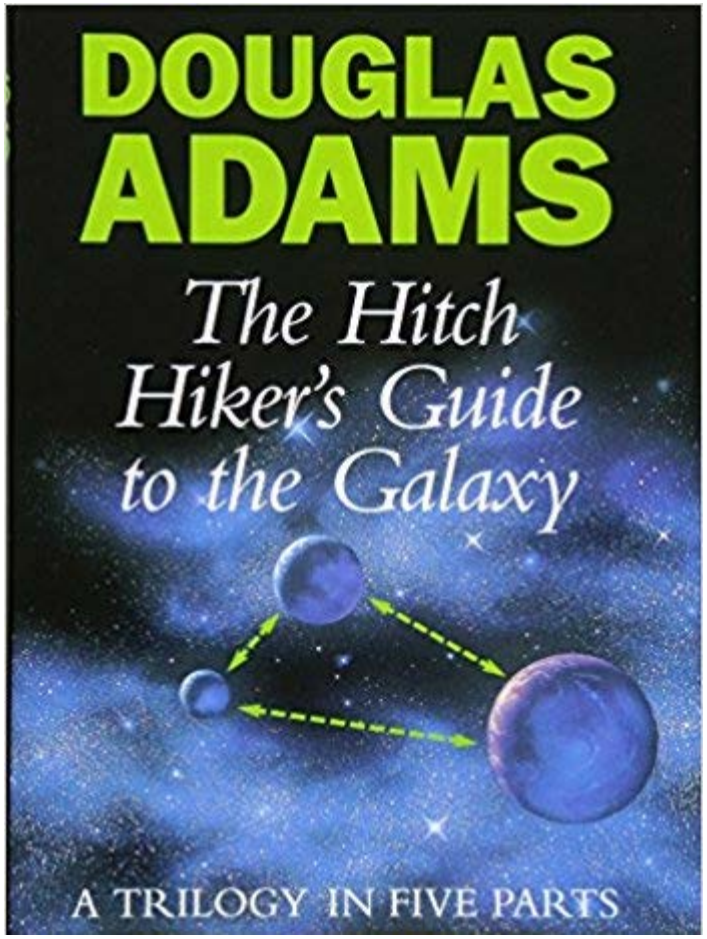
Savage Chickens

by Doug Savage

www.savagechickens.com

It’s complicated and confusing…

“All you really need to know for the moment is that the universe is a lot more complicated than you might think, even if you start from a position of thinking it's pretty damn complicated in the first place.”



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