Choosing Wisely Canada

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Disclosure

None

Outline

1. CSIM CWC subcommittee update
2. Successful implementation strategies and panel discussion
3. Q&A

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CSIM
Canadian Society of Internal Medicine

Five Things Physicians and Patients Should Question

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

Although an uncommon cause for syncope, providers must consider a neurological cause in every patient presenting with transient loss of consciousness. In the absence of signs or symptoms concerning for neurological causes of syncope (such as but not limited to focal neurological deficits), the utility of neuro-imaging studies are of limited benefit. Despite a lack of evidence for the diagnostic utility of neuroimaging in patients presenting with true syncope, providers continue to perform brain computed tomographic (CT) scans. Thus, inappropriate use of this diagnostic imaging modality carries high costs and subject patients to the risks of radiation exposure.

2 Don't place, or leave in place, urinary catheters without an acceptable indication (such as critical illness, obstruction, palliative care).

Use of urinary catheters without an acceptable indication of use increases the likelihood of infection leading to greater morbidity and health care costs. Catheter-associated bacteriuria often leads to inappropriate antimicrobial use and secondary complications including emergence of antimicrobial-resistant organisms and infection with clostridium difficile. A previous study showed that physicians are often unaware of urinary catheterization among their patients. Use of urinary catheters has found to be inappropriate in up to 50% of cases, with urinary incontinence listed as the most common reason for inappropriate and continued placement of urinary catheters. Clinical practice guidelines support the removal or avoidance of unnecessary urinary catheters in order to reduce the risk of catheter-associated urinary tract infections (CAUTIs).

3 Don't transfuse red blood cells for arbitrary hemoglobin or hematocrit thresholds in the absence of symptoms, active coronary disease, heart failure or stroke.

Indications for blood transfusion depend on clinical assessment and are also guided by the etiology of the anemia. No single laboratory measurement or physiologic parameter can predict the need for blood transfusion. Transfusions are associated with increased morbidity and mortality in high-risk hospitalized inpatients. Adverse events range from mild to severe, including allergic reactions, acute hemolytic reactions, anaphylaxis, transfusion related acute lung injury, transfusion associated circulatory overload, and sepsis. Studies of transfusion strategies among multiple patient populations suggest that a restrictive approach is associated with improved outcomes.

4 In the inpatient setting, don't order repeated CBC and chemistry testing in the face of clinical and lab stability.

Repetitive inpatient blood testing occurs frequently and is associated with adverse consequences for the hospitalized patient such as iatrogenic anemia, and pain. A Canadian study showed significant hemoglobin reductions as a result of phlebotomy. Given that anemia in hospital patients is associated with increased length of stay, readmission rates and transfusion requirements, reducing unnecessary testing may improve outcomes. Studies support the safe reduction of repetitive laboratory testing without negative effects on adverse events, readmission rates, critical care utilization or mortality. Laboratory reduction interventions have also reported significant cost savings.

5 Don't routinely perform preoperative testing (such as chest X-rays, echocardiograms, or cardiac stress tests) for patients undergoing low risk surgeries.

Routine preoperative tests for low risk surgeries results in unnecessary delays, potential distress for patients and significant cost for the health care system. Numerous studies and guidelines outline lack of evidence for benefit in routine preoperative testing (e.g., chest X-ray, echocardiogram) in low risk surgical patients. Economic analyses suggest significant potential cost savings from implementation of guidelines.

Implementation

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Pick a target

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Implement

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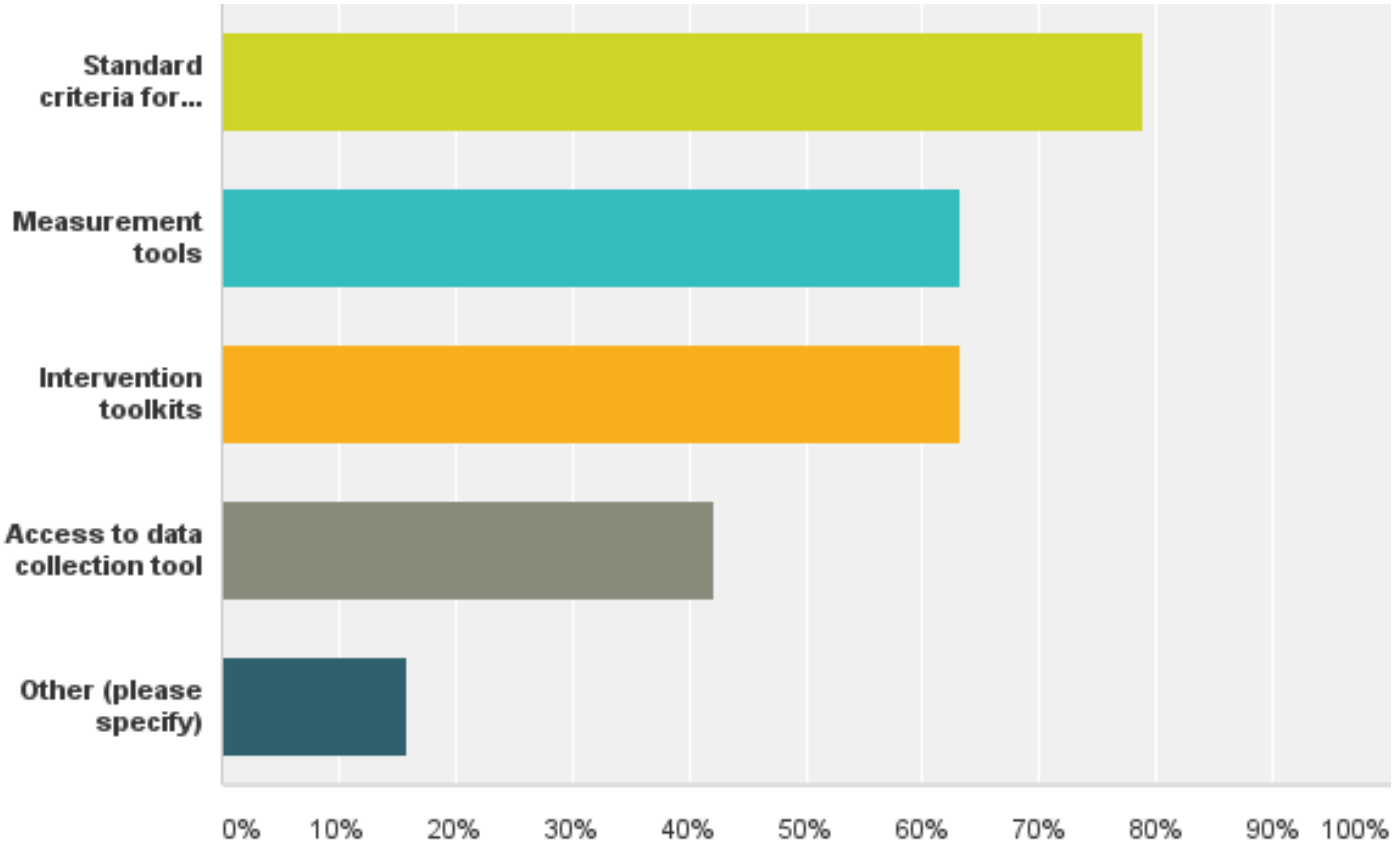
Choosing Wisely Canada
WHY GIVE TWO WHEN ONE WILL DO?
(CSTM#2)
Make Choosing Wisely your next improvement project.
Join the campaign to prevent 10 million unnecessary tests and treatments by 2020.

Urinary catheter needs assessment

- Survey sent to AMC across Canada
- 24 responses (~80%)
- Participating provinces: BC, AB, MB, ON, QC, NS, NL, PEI
- Assessed:
  1. Surveillance programs (40%)
  2. Active reduction programs (15 – 45%)
  3. Interest in resource tool

What resources might be useful to your facility in a UC reduction program?



Panel introduction

1. National CTU UC Survey Results
   - Todd Lee

2. A tale of 2 successful CWC implementation strategies:
   - Jerome Leis: UC reduction at SBK
   - Emily McDonald: Restrictive transfusion strategy

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