



Choosing Wisely Canada : Embedding its Principles within Family Health Teams

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Presenter Disclosure

- **Presenters: Kimberly Wintemute, Sue Griffis**
- **Relationships with commercial interests:**
 - **Grants/Research Support:** None
 - **Speakers Bureau/Honoraria:** None
 - **Consulting Fees:** None
 - **Other:** None

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- This program has not received financial support from an organization
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- Potential for conflict(s) of interest: None

Objectives

- Understand significance of Choosing Wisely
- Imagine how to embed recommendations into team practice
- See how inter-FHT partnerships can work to strengthen FHT QI

Adopting Research to Improve Care

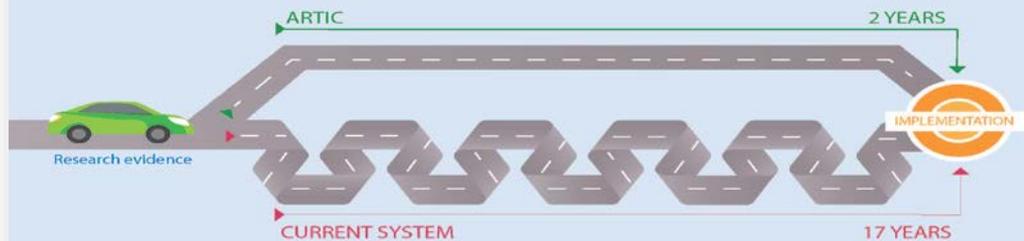
Launched by CAHO in 2010 to foster collaboration & establish systematic approach to moving research evidence from bench to bedside



ARTIC

The ARTIC Program
is a proven
implementation
infrastructure.

A fast-track that accelerates the spread of research evidence.





Choosing Wisely Canada



A campaign to help clinicians and patients engage in **conversations** about unnecessary tests and treatments





Slow Food[®]

Slow Medicine





Five Things Physicians and Patients Should Question

1 Don't order specialized audiometric and vestibular neurodiagnostic tests in an attempt to screen for peripheral vestibular disease.

The diagnosis of the dizzy patient should be guided by the presenting symptoms and office examination. Tests such as ABR (auditory brainstem response), ECOG (electrocochleography), ENG/VNG (electronystagmography)/videonystagmography), VEMP (vestibular evoked myogenic potential), vHIT (video head impulse test), CDG (computerized dynamic posturography) and RCT (rotational chair testing) should only be ordered if clinically indicated. In general, advanced balance tests should be ordered and interpreted by otolaryngologists with specialized training in the diagnosis and treatment of vestibular disorders (otologists/neurotologists). Clinical indications for testing can include: side localization and stage of progression for Meniere's disease, assessment of central compensation for acute vestibular loss and confirmation of superior semicircular canal dehiscence syndrome. Specialized tests are rarely indicated in the management of benign paroxysmal positional vertigo.

2 Don't perform computed tomography or blood work in the evaluation of a patient with sudden sensorineural hearing loss (SSNHL) given its presumed viral etiology.

Blood work which typically would consist of a CBC, differential and electrolytes along with an autoimmune panel are often normal and would not change initial clinical management if abnormal. The CT scan which is done to rule out central causes is not sensitive enough to pick up most cases of retrocochlear pathology. MRI scans should be considered instead. If verified to be sensorineural with audiometric testing, urgent treatment with steroid therapy can be initiated. There is no role for antiviral treatment, thrombolysis or vasoactive substances.

3 Don't perform auditory brainstem responses (ABR) in patients with asymmetrical hearing loss. Asymmetrical hearing loss is defined as bone conduction threshold difference of:

- 20 dB threshold difference at a single frequency
- 15 dB threshold difference at 2 frequencies
- 10 db threshold difference at 3 frequencies

If there is no obvious cause of the asymmetry such as unilateral trauma or unilateral noise exposure like gun blasts, a MRI should be ordered. MRI scans are superior in sensitivity for detecting retrocochlear pathologies such as vestibular schwannoma when compared to ABR testing.

4 Don't use oral antibiotics as a first line treatment for patients with painless ear drainage associated with a tympanic membrane perforation or tympanostomy tube unless there is evidence of developing cellulitis in the external ear canal skin and pinna.

First line therapy constitutes a short course of topical antibiotic/steroid drops. The potential ototoxicity of any topical medication entering the middle ear space should be considered in selecting an appropriate agent. Where available, fluoroquinolone combination preparations (e.g., ciprofloxacin and dexamethasone) should be used as a first choice and caution should be exercised in using topical aminoglycosides. Microdebridement and further assessment should be considered in the following circumstances: (a) failure to respond after a 7 day course, or (b) when follow up does not permit a clear view of a normal tympanic membrane allowing the exclusion of more sinister middle ear disease such as cholesteatoma.

5 Don't perform particle repositioning maneuvers (Epley or Semont) without a clinical diagnosis of posterior semicircular canal benign paroxysmal positional vertigo in the affected ear.

Posterior semicircular canal benign paroxysmal positional vertigo should be diagnosed and confirmed with a positive Dix-Hallpike test, and only then should a particle repositioning maneuver be performed. If a patient with positional vertigo has a Dix-Hallpike test that is repeatedly negative or results in atypical nystagmus, less common BPPV variants or central positional vertigo should be considered.

How the list was created

This list was created by the Otolaryngology & Neurotology subspecialty group of the Canadian Society of Otolaryngology – Head & Neck Surgery. Members of the group, representing the national leaders within the subspecialty were asked to create a list of recommendations for unnecessary tests that were seen to be commonly ordered or unnecessary interventions that were commonly performed. These unnecessary tests and interventions are often invasive and incur risk to patients and unwarranted costs to our public health care system. The evidence was then reviewed to further refine the recommendations. The final version of the list was then circulated and approved by the members of the group.

Sources

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About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help clinicians and patients engage in conversations about unnecessary tests and treatments and help physicians and patients make smart and effective choices to ensure high-quality care.

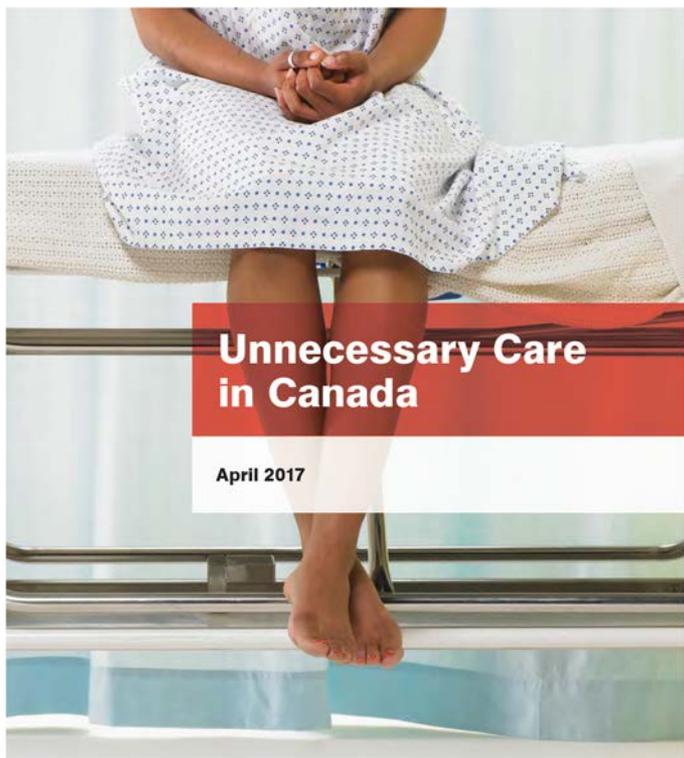
For more information on Choosing Wisely Canada or to see other lists of Things Physicians and Patients Should Question, visit www.choosingwiselycanada.org. Join the conversation on Twitter @ChooseWiselyCA.

About The Canadian Society of Otolaryngology-Head & Neck Surgery

The Canadian Society of Otolaryngology-Head & Neck Surgery (CSO-HNS) is a proud partner of the Choosing Wisely Canada campaign. CSO-HNS is an association that exists to serve the Canadian Otolaryngology-Head & Neck Surgery community. It is composed exclusively of otolaryngologists-head & neck surgeons and those training in the specialty. CSO-HNS is dedicated to improving patient care through the support of education, the promotion of research, the dissemination of information, the scientific advancement of the Society, and the maintenance of high professional and ethical standards.

Sustainability Challenge

- 28% lumbar spine MRIs inappropriate (AB,ON)
- 28% DEXA scans inappropriate (ON); 17% (AB)
- 31% low-risk surgeries get pre-op ECG (ON)
- 32% RBC transfusions inappropriate (ON)



Unnecessary Care in Canada

April 2017

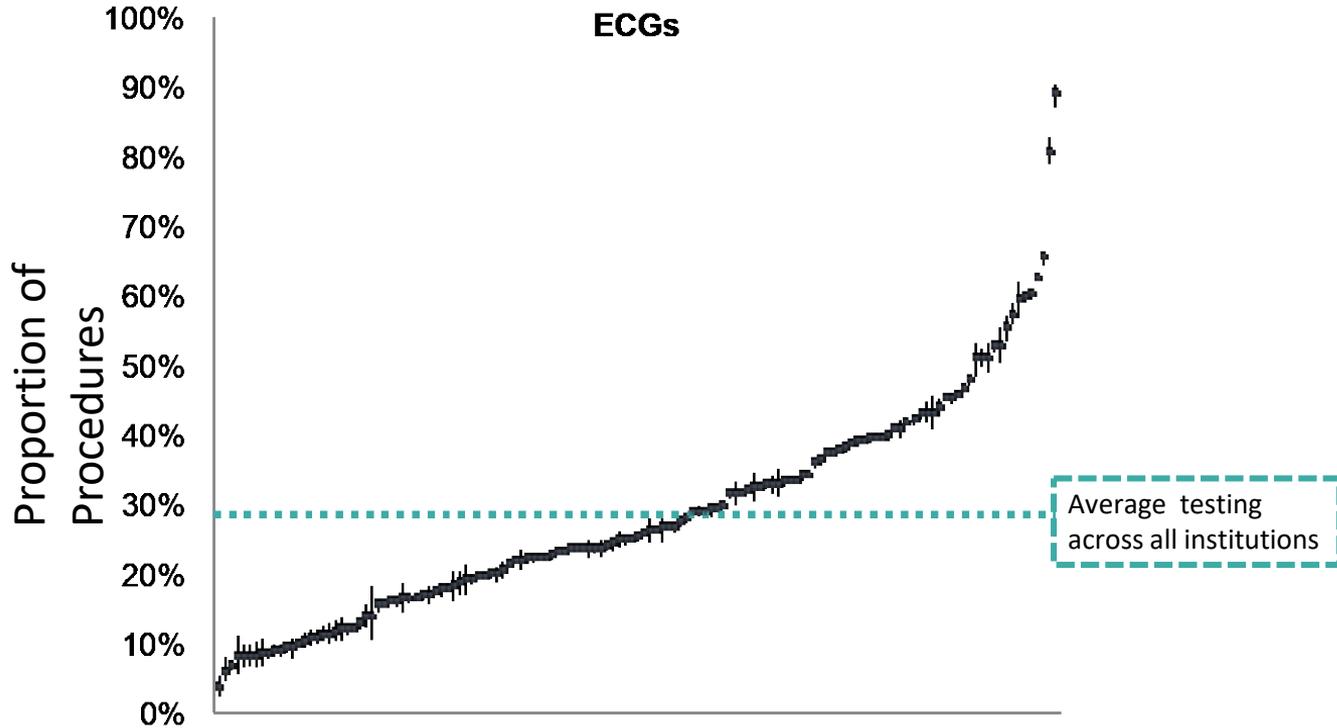
Choosing
Wisely
Canada

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

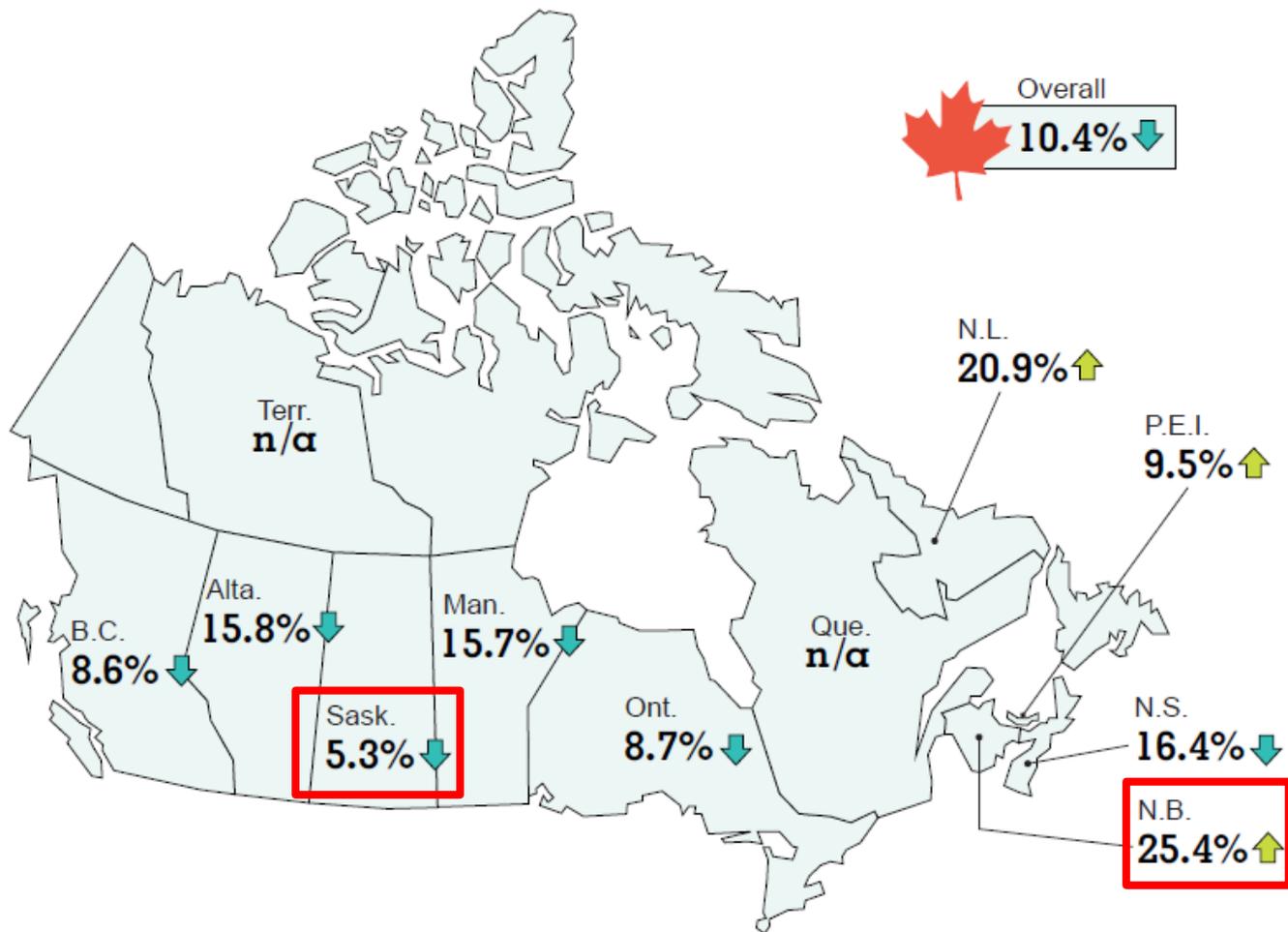
The report found that up to **30%** of the tests, treatments and procedures associated with the 8 selected CWC recommendations are potentially unnecessary.



Preoperative testing in Ontario: ECGs



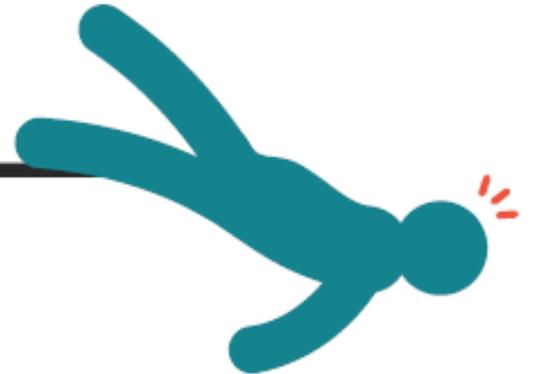
Rate of Chronic Benzodiazepine use Among Seniors



Why is it important?

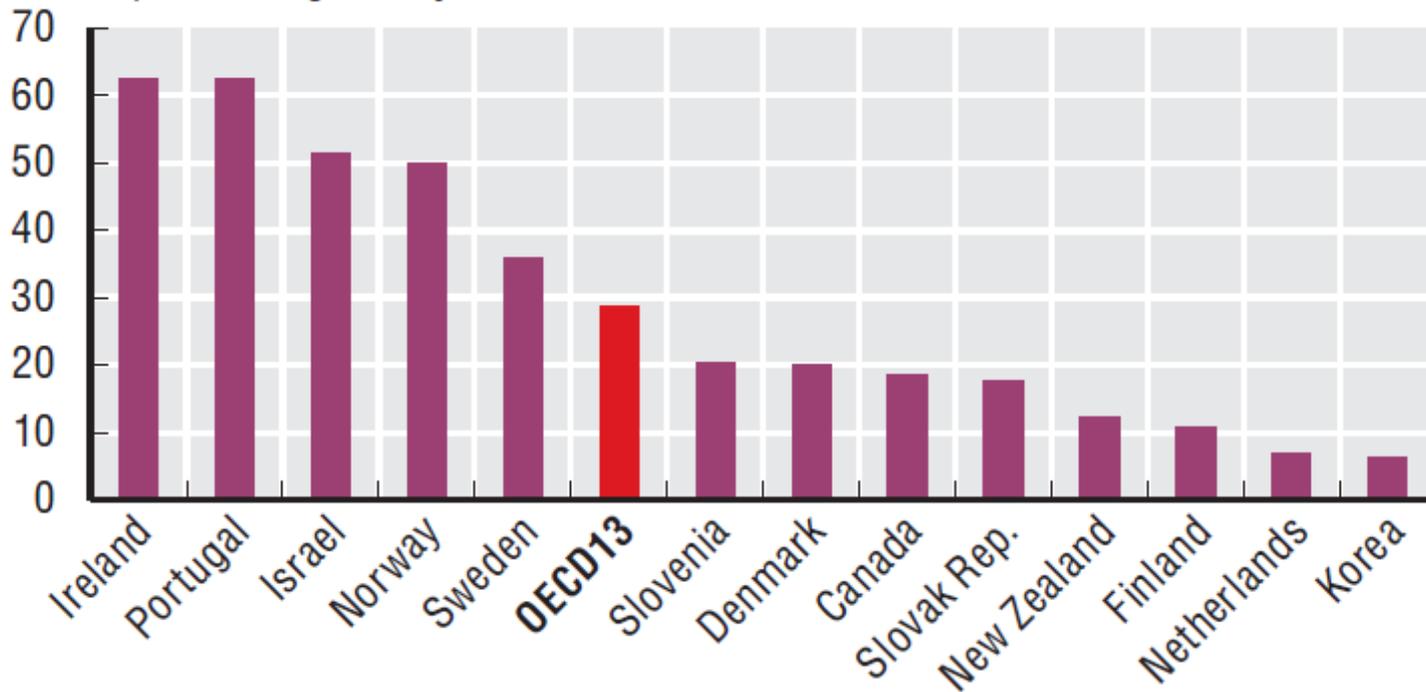


Older adults who use benzodiazepines or other sedative – hypnotics are at an increased risk for motor vehicle accidents, falls and hip fractures and daytime fatigue. Thinking can also be affected

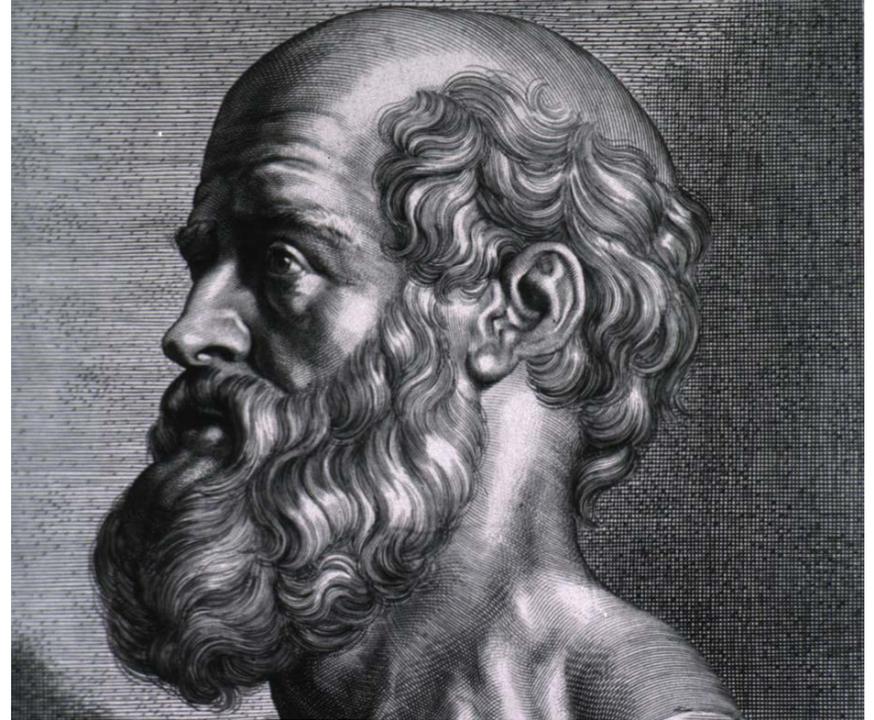


Elderly people prescribed long-term benzodiazepines or related drugs 2013

Per 1 000 persons aged 65 years and over



Why Choose Wisely?



“Routine” Pre-Operative Chest X-Ray

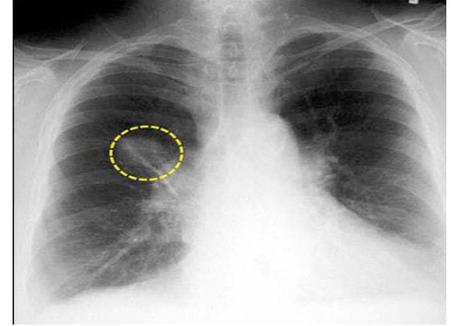
- *64-yo left knee pain x 1 year*
- *Severe osteoarthritis*
- *Plan: knee replacement*
- *Well, no meds. No cardiac or respiratory problems, never smoked*
- *“Routine” pre-op CXR*



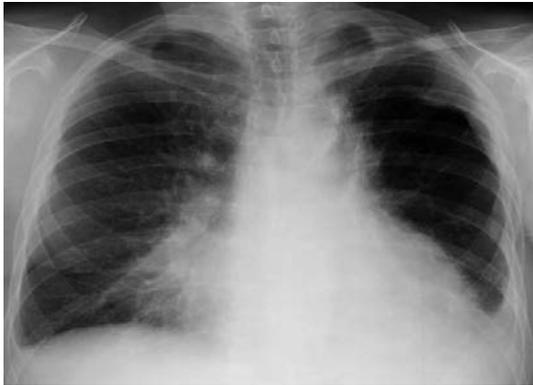
IHI Open School Module QCV 100

Unexpected Finding

- *Small nodule right lung*
- *Surgery delayed to investigate*
- *CT chest, biopsy, respirology appts*
- *6 months later: benign*
- *Knee surgery 3 months later*



Antibiotics “Just In Case” in a Patient with Aspiration Pneumonitis



Teachable Moment, JAMA Internal Medicine, Apr 2015



MORE IS
NOT
ALWAYS
BETTER



MORE IS
NOT
ALWAYS
BETTER

FOUR QUESTIONS TO ASK YOUR DOCTOR

- 1) Do I really need this test, treatment or procedure?
- 2) What are the downsides?
- 3) Are there simpler, safer options?
- 4) What happens if I do nothing?

Change starts with Clinicians



Resource Stewardship



Shared Decision-Making





ARTIC

**CHOOSING WISELY: An *Idea*
Worth *Spreading***



North York
Family Health Team



Markham Family Medicine Teaching Unit
Health for All
FAMILY HEALTH TEAM

MARKHAM
FAMILY HEALTH TEAM

ST
JOSEPH'S
HEALTH CENTRE TORONTO



South East Toronto
Family Health Team

Southlake Academic
Family Health Team

Which Choosing Wisely recommendations should we work on?



Eleven Things Physicians and Patients Should Question

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

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

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

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

3 **Don't order screening chest X-rays and ECGs for asymptomatic or low risk outpatients.**

There is little evidence that detection of coronary artery stenosis in asymptomatic patients at low risk for coronary heart disease improves health outcomes. False positive tests are likely to lead to harm through unnecessary invasive procedures, over-treatment and misdiagnosis. Chest X-rays for asymptomatic patients with no specific indications for the imaging have a trivial diagnostic yield, but a significant number of false positive reports. Potential harms of such routine screening exceed the potential benefit.

4 **Don't screen women with Pap smears if under 21 years of age or over 69 years of age.**

- Don't do screening Pap smears annually in women with previously normal results
- Don't do Pap smears in women who have had a hysterectomy for non-malignant disease

The potential harm from screening women younger than 21 years of age outweighs the benefits and there is little evidence to suggest the necessity of conducting this test annually when previous test results were normal. Women who have had a full hysterectomy for benign disorders no longer require this screening. Screening should stop at age 70 if three previous test results were normal.

5 **Don't do annual screening blood tests unless directly indicated by the risk profile of the patient.**

There is little evidence to indicate there is value in routine blood tests in asymptomatic patients; instead, this practice is more likely to produce false positive results that may lead to additional unnecessary testing. The decision to perform screening tests, and the selection of which tests to perform, should be done with careful consideration of the patient's age, sex and any possible risk factors.

6 **Don't routinely measure Vitamin D in low risk adults.**

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

≈ 90 Choosing Wisely Canada Recommendations Apply to Primary Care

- Framework for considering recommendations to implement
 - Stratified by QI Pillar
 - Is it relevant at our site?
 - Is it measurable?

<https://choosingwiselycanada.org/family-medicine/>

Psychiatry, Hospitalist, Geriatrics Lists



Canadian Psychiatric Association
Association des psychiatres du Canada



Canadian Academy of Child and
Adolescent Psychiatry
Académie canadienne de psychiatrie
de l'enfant et de l'adolescent



cagp | acgp
CANADIAN ACADEMY OF
GERIATRIC PSYCHIATRY | ACADEMIE CANADIENNE
DE GERONTOPSYCHIATRIE



Canadian Society of
Hospital Medicine



CGS-SCG

Canadian Geriatrics Society

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

Gastroenterology List



Don't maintain long term PPI therapy for GI symptoms without an attempt to stop / reduce PPI at least once per year in most patients

Geriatrics List



The Canadian Geriatrics Society

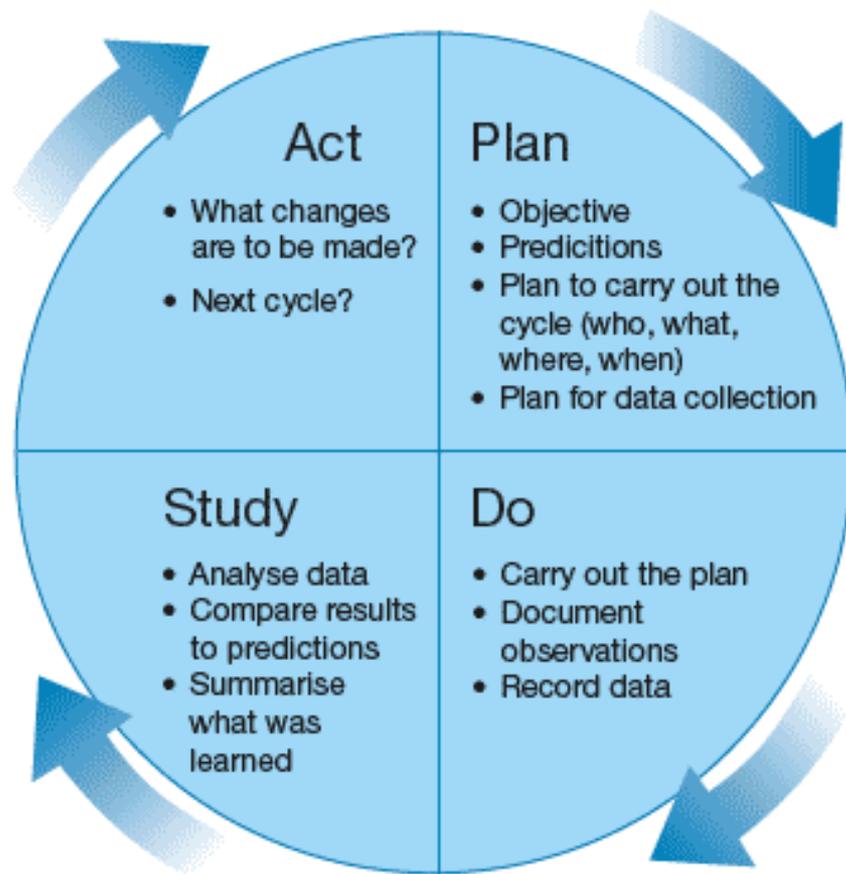
Promoting excellence in healthcare for older Canadians

Avoid using medications known to cause hypoglycemia to achieve HbA1c < 7.5% in many adults age 65 and older; moderate control is generally better

Endocrinology List



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



Choosing
Wisely
Canada



DROWSY WITHOUT FEELING LOUSY

A toolkit for reducing inappropriate use of benzodiazepines and sedative-hypnotics among older adults in primary care.

```
graph LR; A((Identify Patients)) --> B((Discuss risks/benefits with evidence-based tool)); B --> C((Social Work: CBT-I)); B --> D((Pharmacy: Medication Tapering));
```

**Identify
Patients**

**Discuss
risks/benefits
with evidence-
based tool**

**Social
Work: CBT-I**

**Pharmacy:
Medication
Tapering**



Why is patient taking a BZRA?

If unsure, find out if history of anxiety, past psychiatrist consult, whether may have been started in hospital for sleep, or for grief reaction.

- Insomnia on its own OR insomnia where underlying comorbidities managed
- For those ≥ 65 years of age:** taking BZRA regardless of duration (avoid as first line therapy in older people)
- For those 18-64 years of age:** taking BZRA > 4 weeks

- Other sleeping disorders (e.g. restless legs)
- Unmanaged anxiety, depression, physical or mental condition that may be causing or aggravating insomnia
- Benzodiazepine effective specifically for anxiety
- Alcohol withdrawal

Engage patients (discuss potential risks, benefits, withdrawal plan, symptoms and duration)

Recommend Deprescribing

Continue BZRA

- Minimize use of drugs that worsen insomnia (e.g. caffeine, alcohol etc.)
- Treat underlying condition
- Consider consulting psychologist or psychiatrist or sleep specialist

Taper and then stop BZRA
(taper slowly in collaboration with patient, for example ~25% every two weeks, and if possible, 12.5% reductions near end and/or planned drug-free days)

- **For those ≥ 65 years of age** (strong recommendation from systematic review and GRADE approach)
- **For those 18-64 years of age** (weak recommendation from systematic review and GRADE approach)
- Offer behavioural sleeping advice; consider CBT if available (see reverse)

Monitor every 1-2 weeks for duration of tapering

Expected benefits:

- May improve alertness, cognition, daytime sedation and reduce falls

Use non-drug approaches to manage insomnia

Use behavioural

If symptoms relapse:

Consider

- Maintaining current BZRA dose for 1-2 weeks, then continue to taper at slow rate

Alternate drugs

- Other medications have been used to manage



You May Be at Risk

You are taking one of the following
sedative-hypnotic medications:

Alprazolam (Xanax®)

Chlorazepate

Diazepam (Valium®)

Estazolam

Temazepam (Restoril®)

Triazolam (Halcion®)

Deprescribing.org

**TEST YOUR KNOWLEDGE
ABOUT THIS MEDICATION**

QUIZ

SEDATIVE-HYPNOTIC DRUGS

1. The medication I am taking is a mild tranquilizer that is safe when taken for long periods of time. **TRUE** **FALSE**
2. The dose that I am taking causes no side effects. **TRUE** **FALSE**

1. FALSE

It is no longer recommended to take a sedative-hypnotic drug to treat insomnia or anxiety. People who take it are putting themselves at a:

- 5-fold higher risk of memory and concentration problems
- 4-fold increased risk of daytime fatigue
- 2-fold increased risk of falls and fractures (hip, wrist)
- 2-fold increased risk of having a motor vehicle accident
- Problems with urine loss

WEEKS		TAPERING SCHEDULE							✓
	MO	TU	WE	TH	FR	SA	SU		
1 and 2									
3 and 4									
5 and 6									
7 and 8									
9 and 10									
11 and 12									
13 and 14									
15 and 16									
17 and 18									

CBT for Insomnia: Two Elements

Stimulus control

- Reduce “bed = awake” association
- Increase “bed = sleep” association

Sleep restriction

- Collect data using sleep log
- Provide sleep prescription

Training Social Work Team

- One MSW, trained others
- Basic training by Dr. Colleen Carney, Ryerson University (<http://drcolleencarney.com/>)
- Advanced training UPenn, 3 days

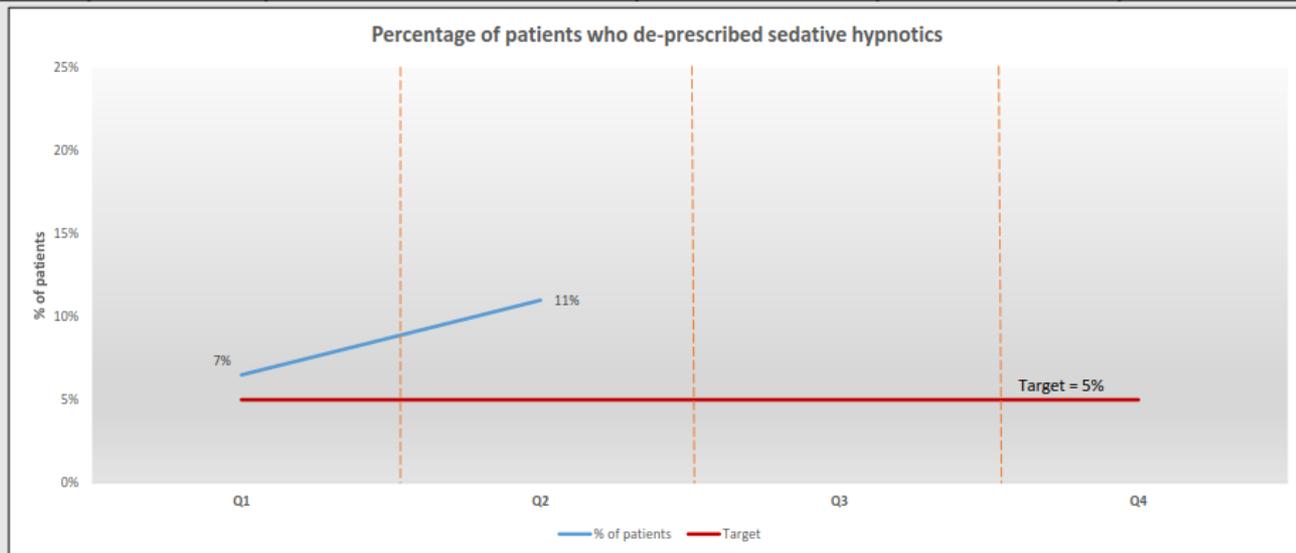
Sedative-Hypnotic Outcomes

	NYFHT	All 6 Sites
May 2017 Baseline	1792	3233
July 2017	1676 (6.5% reduction)	3069 (5% reduction)



NYFHT Q1 2017 - 2018 De-prescribing sedative hypnotics

DOMAIN	INDICATOR	Fiscal year 2017-18								
		Q1			Q2		Q3		Q4	
Patient Safety	Percentage of patients 65 and over who de-prescribed sedative hypnotics	Number of patients on sedative hypnotics	Number of patients who de-prescribed sedative hypnotics	% (cumulative)	Number of patients who de-prescribed sedative hypnotics	% (cumulative)	Number of patients who de-prescribed sedative hypnotics	% (cumulative)	Number of patients who de-prescribed sedative hypnotics	% (cumulative)
		1792	116	6.5%	193	11%				



Note : Following the same cohort (1792 patients) through out the fiscal year.

Baseline : 1792 out of 19,324 patients (who are 65 and over) were on sedative hypnotics as of March 2017

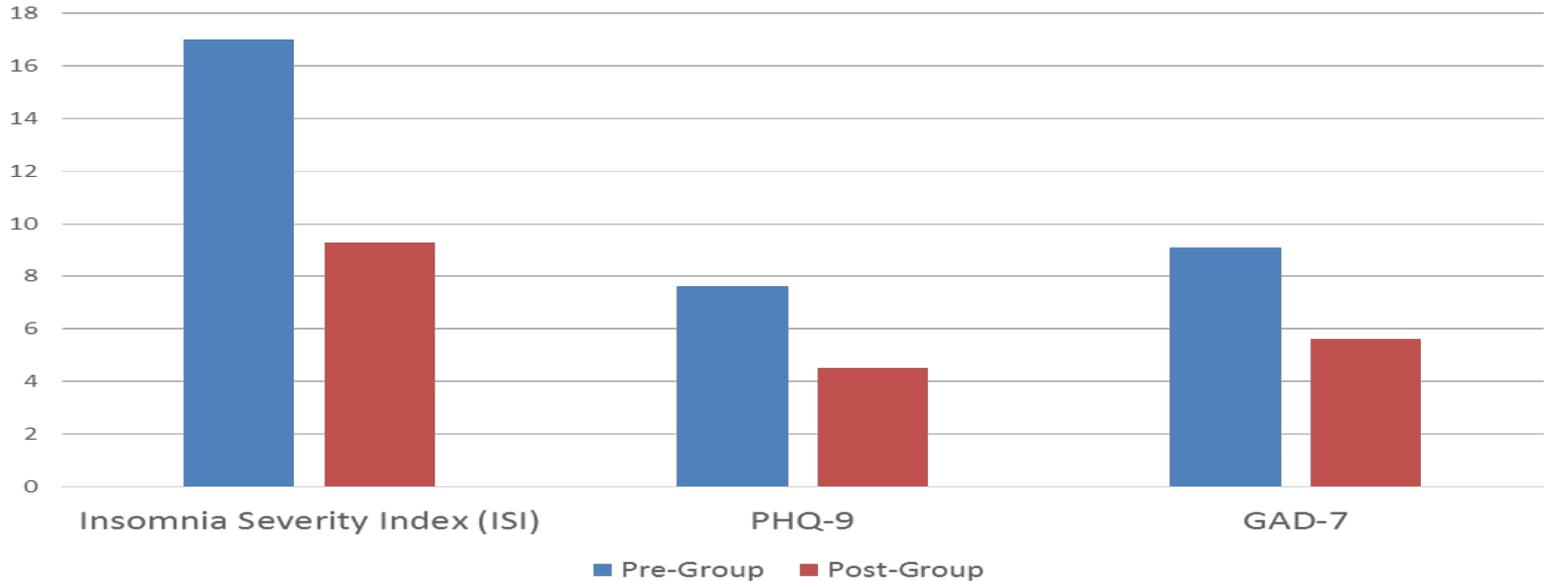
October 19, 2017

CBT-I at NYFHT

- 4 groups, 33 participants
- Fall 2016 group:
 - 7/7 stopped meds
- Spring 2017 group:
 - 6/8 stopped meds
 - 1 reduced dose
 - 1 working with SW & pharmacy on slow taper

CBT-I Groups

(n=33)





Choosing
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Canada



BYE-BYE, PPI.

**A toolkit for deprescribing proton pump inhibitors
in EMR-enabled primary care settings**

Long-term use PPI

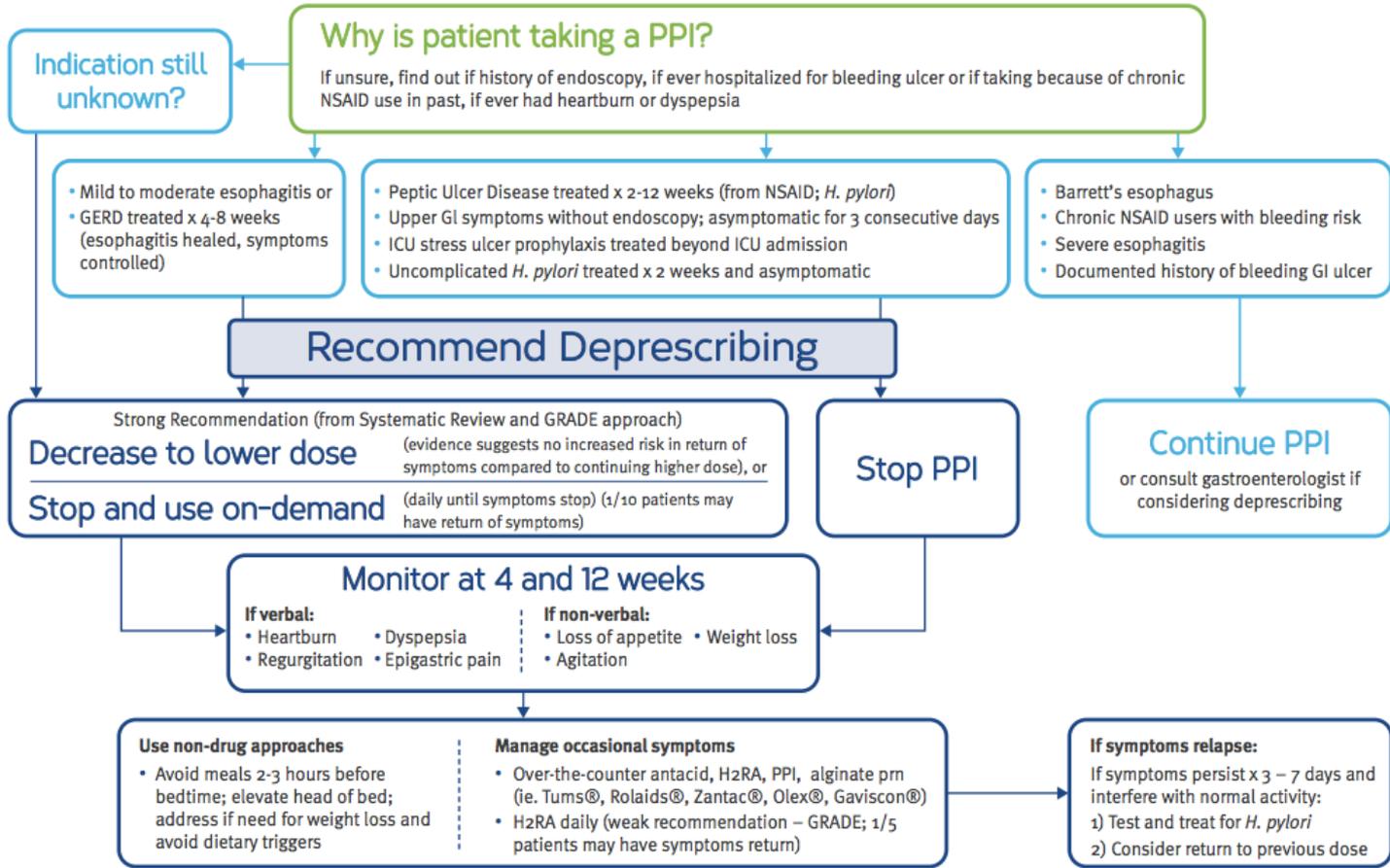
30-60% lack appropriate indication

Risks

- Community-acquired & hospital-acquired pneumonia
- C. Difficile
- Fractures
- Chronic kidney disease
- Low magnesium: arrhythmia, myalgias, tremors
- B12 Deficiency

Who should stay on PPI?

- Chronic NSAID use
- Hx GI bleed
- Barrett's esophagus
- Los Angeles Grade D (Severe) Esophagitis



SHOULD I KEEP TAKING MY ACID REFLUX MEDICATION?

A consult decision aid for you to discuss whether to continue your proton pump inhibitor (PPI)

1. Why am I being offered this choice?

YOU HAVE TAKEN A PPI FOR AT LEAST 4 WEEKS (to treat mild/moderate heartburn or acid reflux)	Acid reflux happens when acid from your stomach travels into your esophagus (a tube that connects the mouth to the stomach). The acid causes heartburn, pain in the throat or trouble swallowing. PPIs stop release of acid in the stomach.
YOU HAVE NO SYMPTOMS	PPIs resolve symptoms and heal about 60 to 80% of patients after 4 to 8 weeks. Some people may not need to keep taking PPIs long-term. Guidelines suggest using the lowest effective dose for the shortest duration.
YOU DO <u>NOT</u> HAVE A REASON TO STAY ON A PPI LONG-TERM	Certain people need PPIs long-term (for example, those taking regular NSAIDs*, those with a history of a stomach bleed, Barrett's esophagus or severe inflammation in their esophagus). It is not be suitable for these people to stop their PPI.

*NSAID = non-steroidal anti-inflammatory drugs (e.g. ibuprofen [Advil], naproxen [Aleve])

2. What are your options?

Deprescribing.org

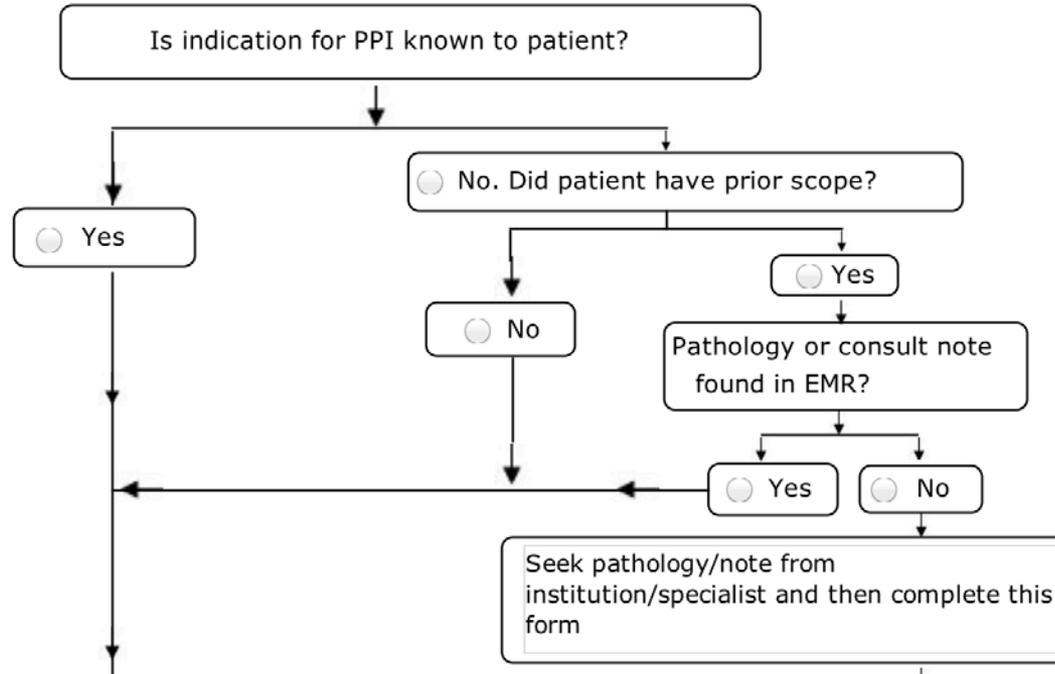


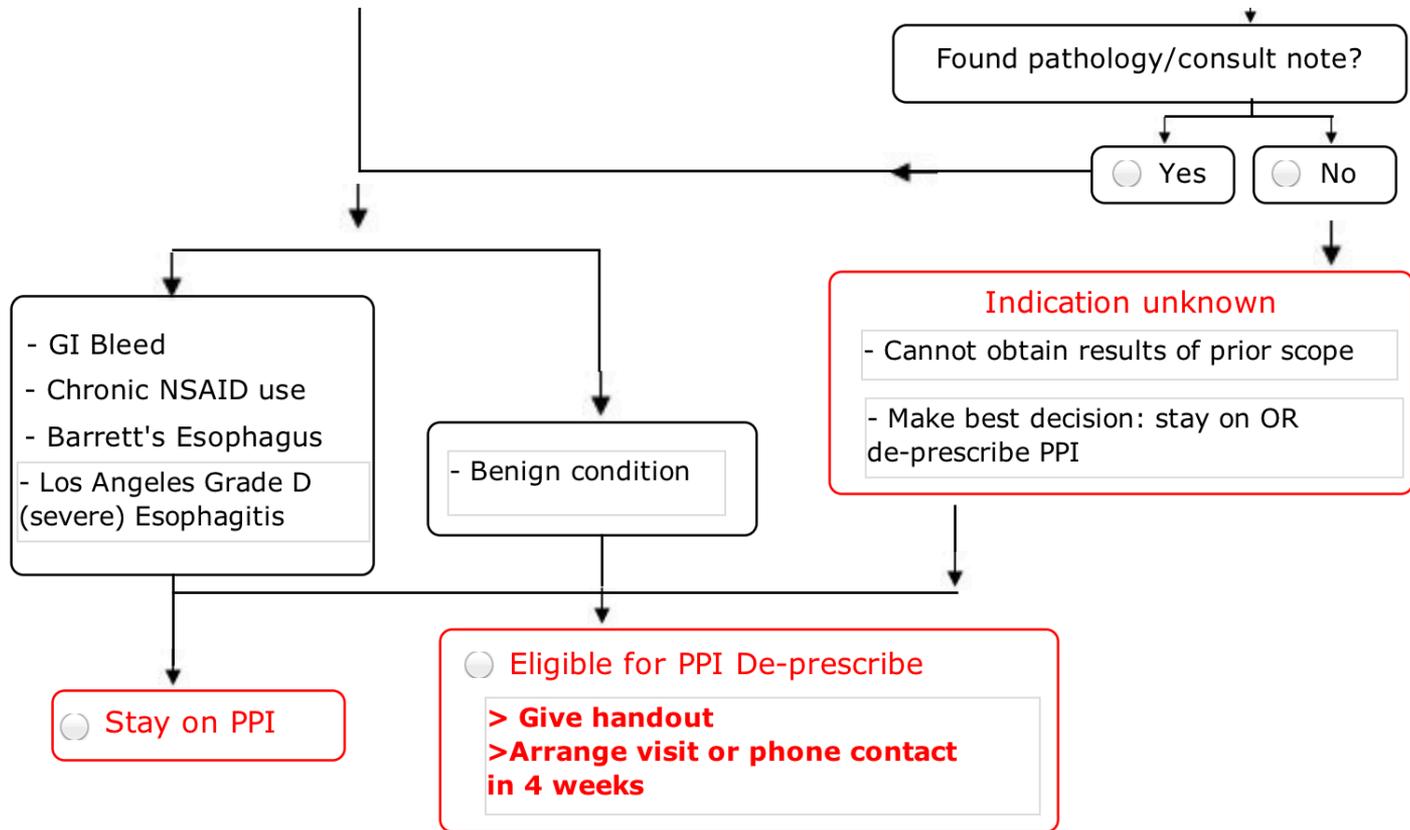
North York

Family Health Team

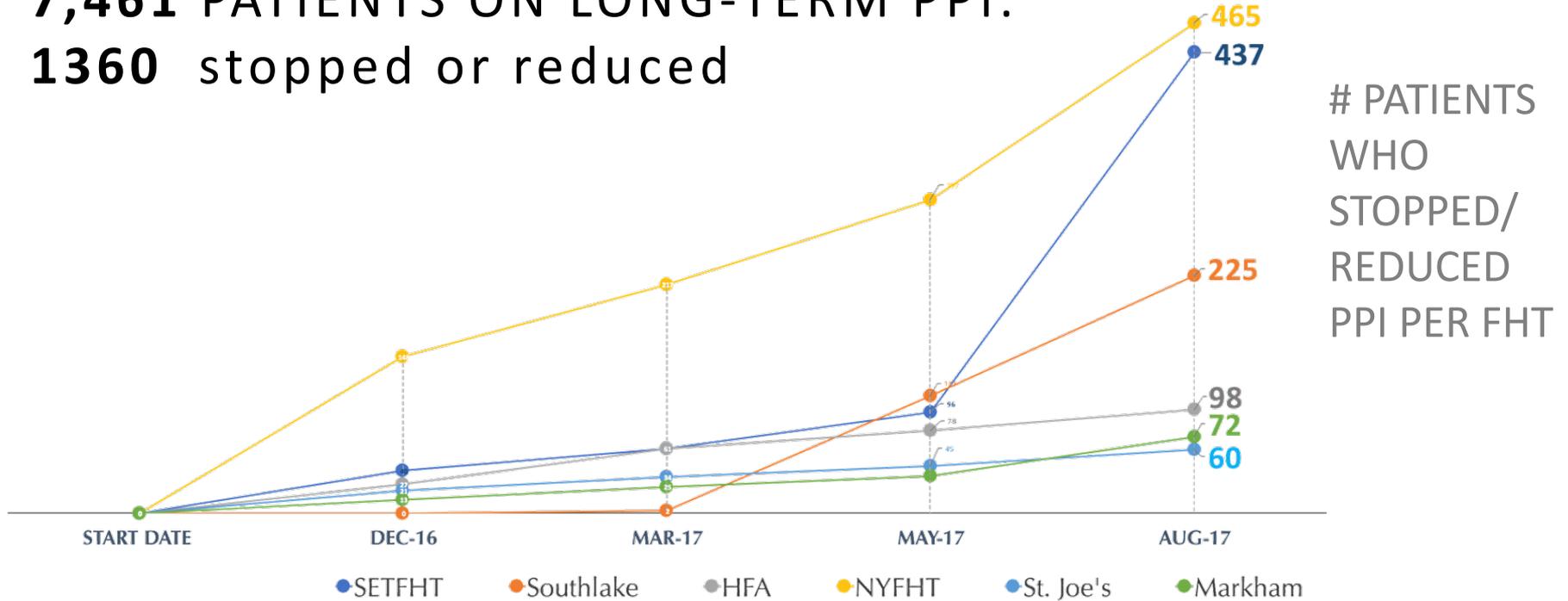
240 Duncan Mill Road, Suite 501, Toronto, ON M3B 3K6

Suitability for de-prescribing Long-Term PPI





7,461 PATIENTS ON LONG-TERM PPI: 1360 stopped or reduced



Deprescribing Glyburide > 65

- Run list of patients
- PDSA #1: MD to re-evaluate
- PDSA #2: Pharmacists review meds; make suggestions to MD by EMR message

Glyburide Outcomes

- Start in May 2017: 107 patients
- July 2017: 67 patients
- 37% absolute reduction

T3 T4

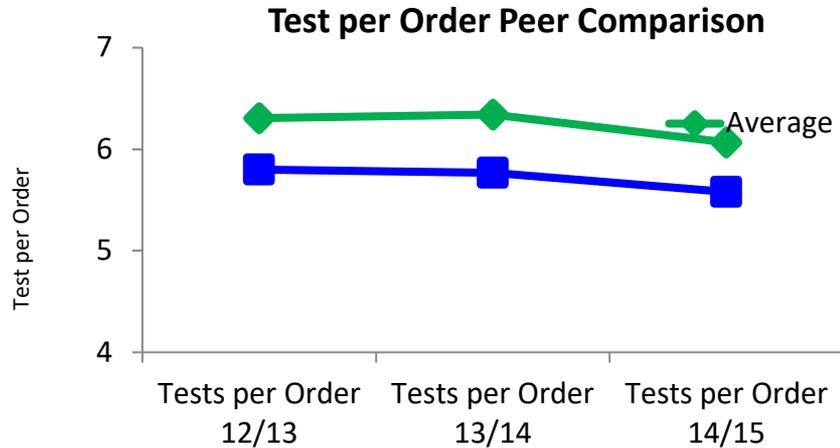
LESS IS MORE WITH T3 & T4

A toolkit for reducing free thyroid hormone testing.



Provider Scorecards

Physician Score Card: Efficiency Compared to Peers



	Top 20 Tests- Dr. QI	Top 20 Tests Peers
1	CREATININE	✓
2	COMPLETE BLOOD COUNT	✓
3	GLUCOSE QUANTITATIVE	✓
4	CHOLESTEROL TOTAL	✓
5	TRIGLYCERIDES	✓
6	HDL CHOL.	✓
7	THYROTROPIN (TSH)	✓
8	SGPT ALT.	✓
9	GLYCOSYLATED HEMOGLOBIN	✓
10	SODIUM	✓
11	POTASSIUM	✓
12	CHLORIDE	✓
13	PROTHROMBINTIME	X#22
14	VITAMIN B12	✓
15	PAP SMEAR	X#40
16	MONOLAYER CELL PAP	X#39
17	SGOT AST	X#35
18	URINE CULTURE	✓
19	FERRITIN	✓
20	CHLAMYDIA CULTURE	X#38

- ✓ Top 20 tests that peers also ordered
- X Test that were not in the Top 20 peer-ordered tests
- # indicates the relative ranking of the test overall

Physician Score Card: Test Ratio Compared to Peers



Test Ratio Comparison: 2012-2015

	Peers	Dr. QI
HbA1C:Glucose	0.7 : 1	0.6:1
TSH:T3	15.3 : 1	80.2 : 1
TSH:T4	4.6 : 1	7.16 : 1
ALT:GGT	3.7 : 1	10.4:1

Selected Tests for Comparison and Rationale

Test	Use	Utilization Challenge
AST	Used to detect liver damage	No treatment-relevant information over existing test. No value-added treatment information over and above ALT.
Gamma GT	To screen for liver disease or alcohol abuse.	High volatility between individuals, skewed by patient behavior. Alcohol consumption directly affects results; little treatment impact
TSH, T3, T4	Help evaluate thyroid gland function & help diagnose thyroid gland disorders.	TSH should be ordered for screening then, if TSH results indicate, T3 and/or T4 are used to identify cause and treatment. However, analysis showed that all three tests were ordered at the same time which unnecessarily drives up cost of testing.

TSH / T3 / T4 outcomes

- Baseline Jan 2017
- Data July 2017: 29% abs reduction TSH:T3
- Among 14 Univ of Toronto Academic FHTs, these 6 have 10% abs reduction in TSH ordering

Are you 65 or older & taking any of these medications?

- Alprazolam (Xanax)
- Clonazepam (Rivotril)
- Diazepam (Valium)
- Flurazepam (Dalmane)
- Lorazepam (Ativan)
- Oxazepam
- Temazepam (Restoril)
- Triazolam (Halcion)
- Zopiclone (Imovane)

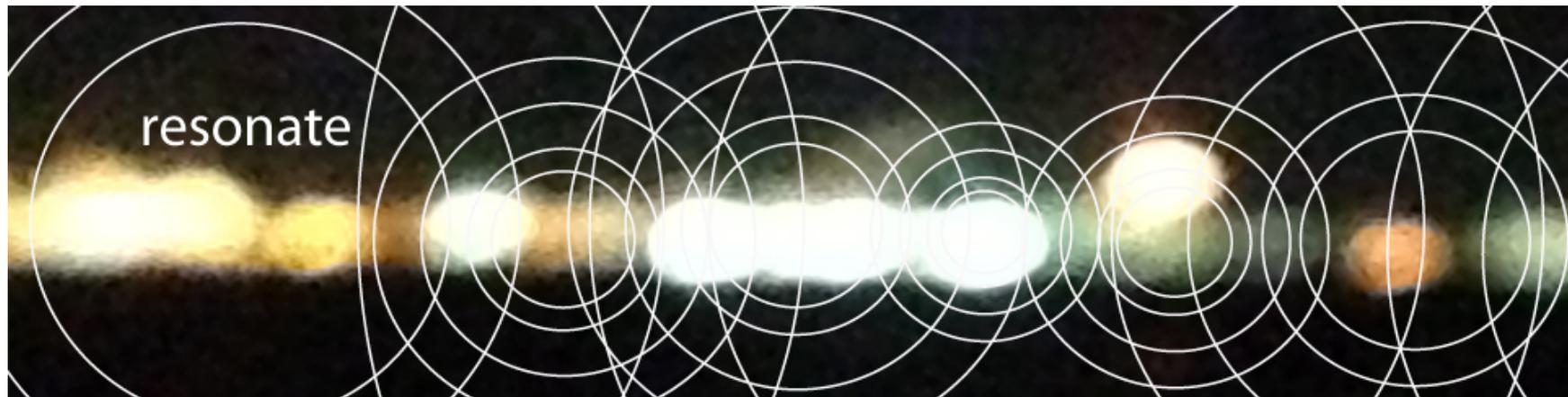


These medications can be harmful in older patients. Please talk to your doctor or nurse-practitioner about the risks versus benefits of continuing to take these.

More information is also available at:

<http://www.criugm.qc.ca/fichier/pdf/BENZOeng.pdf>





Implementation tips...

- Choose recommendation that fits your team
- Use existing evidence-based resources
- Put on your QIP



Home

Recommendations

Related Recommendations:

- [Other Choosing Wisely Canada Recommendations Relevant to Primary Care](#)

Patient Materials:

- [Bone Density Tests: When you need them and when you don't](#)
- [ECG \(Electrocardiogram\): When you need it and when you don't](#)
- [Health Check-ups: When you need them and when you don't](#)
- [Imaging Tests for Lower Back Pain: When you need them and when you don't](#)
- [Pap Tests: When you need them and when you don't](#)
- [Treating Sinusitis: Don't rush to antibiotics](#)
- [Vitamin D Tests: When you need them and when you don't](#)

College of Family Physicians of Canada Resources:



QIP – mandatory measures?

“Our FHT is a participant in the ARTIC Project entitled, *Choosing Wisely: An Idea Worth Spreading*. **We are actively engaged in the following measures** as a part of this Project: *De-prescribing PPIs; De-prescribing Glyburide in patients > age 65; De-prescribing Sedative-Hypnotics in patients > age 65; and decreasing low-value lab test utilization, especially orders for T3 and free T4 with TSH.*

As such, we will not be reporting on this particular measure for 2017-18.”

“Our FHT is a participant in the ARTIC Project entitled, Choosing Wisely: An Idea Worth Spreading. We are actively engaged in the following measures as a part of this Project: De-prescribing PPIs; De-prescribing Glyburide in patients > age 65; De-prescribing Sedative-Hypnotics in patients > age 65; and decreasing low-value lab test utilization, especially orders for T3 and free T4 with TSH. The six FHTs involved in this project are Health For All, St. Joe’s Urban, Markham, North York, Southeast Toronto and Southlake”.



Ontario

Health Quality Ontario



Work with other FHTs to yield larger body of data

- If you
 - share QIDDS
 - have same EMR
 - have a common QI goal

Inter-FHT QI Partnerships

- Share your
 - aim statements
 - comments
 - rationale
- Stay independent on your
 - change ideas
 - methods







**“I feel a lot better since I ran out
of those pills you gave me.”**

Resources

- deprescribing.org (evidence-based algorithms, patient decision aids)
- <http://www.hqontario.ca/Quality-Improvement/Quality-Improvement-in-Action/ARTIC/Call-for-Proposals> (information on submitting a proposal for an ARTIC grant)
- <https://choosingwiselycanada.org/family-medicine/> (family medicine list of Choosing Wisely Canada)
- info@nyfht.com (for PSS or Accuro searches / reminders)
- <http://ocfp.on.ca/cpd/practising-wisely> (for information on bringing Practising Wisely course to you)
- info@choosingwiselycanada.org (for Choosing Wisely posters & materials)