



Choosing Wisely at Island Health: Putting Recommendations into Practice

Sli.Do Panel Q&A

Thank you for your interest and participation in the virtual symposium, held on November 20, 2020.

[Choosing Wisely Recommendation Questions](#)

Answered by Dr. Adele Harrison and Dr. Jessica Otte.

1. Patient/family expectations can make it challenging to address Choosing Wisely. I look like the “bad guy” by denying a test or treatment. How can we address this?

Choosing Wisely recommendations are meant to spur conversation about what is appropriate and necessary treatment. As each patient situation is unique, clinicians and patients could use the Choosing Wisely Canada materials to determine an appropriate treatment plan together. Consider exploring patient’s specific goals, at the root of their requests, and framing your recommendations around those goals rather than the specific requests. Specific [patient focused materials](#) are available from Choosing Wisely Canada and “[Practising Wisely](#)” professional development courses are offered by the BC College of Family Physicians.

2. What if I follow a Choosing Wisely recommendation and the patient suffers harm because something is missed? Do our professional bodies support Choosing Wisely?

The CMPA works closely with Choosing Wisely. Through a focus on enhancing the safety of medical care, the [CMPA](#) recommends that guidelines are followed and highlights the importance of effective communication. Concerns about malpractice can drive unnecessary ordering of tests and treatments in order to be thorough and cover all clinical possibilities are recognised and in [December’s Choosing Wisely Talks](#), communication approaches, tools, and strategies to address these complicated practice issues are discussed.

3. Measuring the changes and the impact of the recommendations is difficult to do. How we can get access to good quality metrics?

Recommendations that are currently part of the Island Health commitment to “[Becoming a Choosing Wisely Hospital](#)” campaign will be supported by appropriate metrics. For access to data at Island Health use the [data request](#) process and email datarequest@viha.ca

4. I try to follow Choosing Wisely but practices are entrenched in our culture & there are expectations from other staff. What can we do to make it easier for busy physicians?

All new and revised order sets are being reviewed for compliance with Choosing Wisely recommendations. New and revised guidelines should also be in alignment with evidence based Choosing Wisely recommendations.

Consider a quality improvement (QI) project using one of the Choosing Wisely Canada [toolkits](#). You may find that if you start small, the staff around you will start shifting their thinking from one initiative into other areas where they wonder if something is really necessary or harmful.

5. I don't have time to educate the staff and the patients about why a test isn't needed. Can we increase awareness of Choosing Wisely?

The aim of engaging in the Choosing Wisely "[Becoming a Choosing Wisely Hospital](#)" campaign is to raise awareness of the Choosing Wisely initiative across Island Health and to support quality improvement that aligns with Choosing Wisely recommendations.

6. I don't always know why a medication was started so it's difficult to remove. How does this get addressed?

The easiest way is to ask the patient, the caregiver, or the community pharmacist or Family Physician/NP. If no one knows the indication for the medications, consider closely monitored deprescribing; the dose can always be increased or the medication restarted if some symptoms re-emerge.

The Choosing Wisely recommendations involving medication prescribing are accompanied by tools to support a staged approach to reducing unnecessary prescribing. Many tools can be found on the Choosing Wisely website, including "[When psychosis isn't the diagnosis](#)" and "[Bye PPI](#)".

We would also suggest "indication based prescribing" – writing the purpose of the medication whenever writing a prescription, so that it will remain on the record/on the pill bottle so the "unknown indication" won't be an issue in the future.

7. Are we measuring negative consequences of choosing wisely?

As we move to level 2 of the Choosing Wisely campaign, the QI projects will include balancing measures as determined by subject matter experts. Choosing Wisely recommendations should be used to guide conversations between providers and patients with decisions based on individual care needs.



8. When guidelines clash with Choosing Wisely providers provide different opinions. Patient's can be left in the middle feeling a loss of trust. How can we address this?

Reducing unwarranted variation in care is associated with improved patient outcomes; evidence based guidelines and order sets support a consistent approach and Choosing Wisely recommendations are included in order set review. The CMPA highlights the importance of effective communication in enhancing the safety of medical care and reducing medico-legal experiences for physicians.

We must use evidence-based medicine, which is the intersection of the best available evidence, the patient's goals and values, and clinician expertise to find the 'right' care for the patient.

9. How does Choosing Wisely incorporate advances in medicine?

Many of the Choosing Wisely recommendations are developed by a panel of experts and are reviewed regularly. Others have more historical roots and may no longer be aligned with evidence based practice. Prior to implementation Island-wide, the recommendations are being reviewed by subject matter experts to ensure they are evidence-based and applicable to the patient population.

10. Island Health is soon moving to CPOE across the island. How can we ensure that Choosing Wisely is embedded in these order sets?

All new and revised order sets are being reviewed for compliance with Choosing Wisely recommendations by the order set committee and orders management clinical decision support committee.



11. Any guidance on how to handle patient choice that may be unwise concerning MOST status? Home 02, metastatic cancer demanding c2? When is paternalism ok?

Before concluding that the patient's choice is unwise, we strongly recommend using the evidence-based [Serious Illness Conversation Guide \(SICG\)](#) in its entirety: booking a specific 15-30 minute appointment (or series of appointments) where you use the SICG, following the order of questions and language very closely. Goals for the discussion:

- What is the **patient's understanding** of their illness? Clear up any misunderstandings.
- Offer **your understanding** of the illness and trajectory.
- Are there any **fears or worries** that are influencing their decision?
- Does the **patient understand what CPR and aggressive measures look like** in the context of their health status? Are they able to reflect that back to you in the "understanding" step in the SICG?
- Do you have **rapport** with the patient? Do they have a **relationship of trust** with you?
- Do you know about the **patient's values, goals, and preferences** for care?

Reminder that it's not just about filling out a form or getting MOST status – it's about understanding the person in front of you and what's most important to them. Often a "demand" for a MOST C2 reflects fear, mistrust or a specific priority. Once these are understood, sometimes it becomes easier to reframe the prognosis and care options as they relate to those fears or priorities. It's also a longitudinal process that takes time. A patient may request C2 MOST initially and it may take multiple discussions over time to establish all of the bolded elements above. It's relatively unusual to have all of the bolded items and still be at odds. In that situation, asking colleagues, possibly a palliative care specialist to assist in the discussions would be appropriate (and may also be appropriate to include palliative care team in their overall care in the context of metastatic cancer or progressive/endstage lung disease, regardless of MOST disagreement/status).

The above approach is supported by the **Island Health MOST Policy**:

- *1.1 A MOST designation will be based on Advance Care Planning (ACP) and Goals of Care discussions with the capable Adult. All members of the health care team may contribute to discussions relevant to a MOST designation. These discussions must be documented.*



- *1.10 Where an Adult has a C2 MOST designation and has had change in their health such that they have an irreversible disease process known to be unresponsive to CPR and there would be no benefit from such interventions, there must be further discussion with the Adult and/or their Substitute Decision Maker. With their agreement, the MOST order should be changed.*

The MOST policy supports staff in withholding Non-beneficial Medical Treatment, however doing that without patient/Substitute Decision Maker agreement is an absolute last resort, only to be considered after all of the above steps, and ideally in consultation with colleagues/support team (e.g. social work, ethics, spiritual care).

- *1.13 In an emergency situation where an Adult is dying from an acute disease process known to be unresponsive to CPR and there would be no benefit from such interventions, a Practitioner is not obligated to offer Non- Beneficial Medical Treatment. Using best clinical judgement, the Practitioner will initiate a clinically appropriate course of treatment and plan of care.*

The MOST policy is, in turn, grounded in the [Health Care \(Consent\) and Care Facility \(Admission\) Act](#):

- **Consent rights:** “Every adult who is capable of giving or refusing consent to health care has ... the right to be involved to the greatest degree possible in all case planning and decision making.”
- **Elements of consent:** “An adult consents to health care if ... the health care provider **gives the adult the information** a reasonable person would require to understand the proposed health care and to make a decision, including information **about**”
 - **the condition** for which the health care is proposed, [“prognosis” step in SICG]
 - **the nature of the proposed health care,**
 - **the risks and benefits** of the proposed health care that a reasonable person would expect to be told about, [“trade-offs” step in SICG]
 - **alternative courses** of health care, and [“trade-offs” step in SICG]
 - **the adult has an opportunity to ask questions and receive answers** about the proposed health care. [“permission”, “understanding” and “prognosis” steps in SICG]



12. How can facilities (owned and operated) chart conversations around Goals of Care as they don't have Cerner access?

All Clinical staff (nurses, doctors, spiritual care etc.) at VIHA-owned-and-operated LTC facilities should already have Cerner login access and should be able to both view (in the Results Review “ACP/MOST” tab) and enter ACP charting in the ACP form in Cerner. The technical option is “live”, we just haven’t yet formally trained LTC staff to use the ACP form to document these conversations.

Having said that, it is very easy to do and instructions are [here](#).

The Ad Hoc button to get into the ACP form looks the same for allied health and physicians/NPs.

Please help us spread the word that this functionality is available in Cerner now and encourage all of your team members to use it. If you know of staff at an owned and operated LTC facility don’t have Cerner access, please let us know rachel.carson@viha.ca or advancecareplanning@viha.ca so we can get that fixed.

If your LTC team would like team training/support to document ACP using Cerner, please let us know. Note the ACP form is different from MOST. The majority of LTC facilities don’t have eMOST implemented yet and so paper MOST forms completed in LTC should still be faxed to the central community MOST line so a VIHA informaticist can enter them electronically into Cerner.

