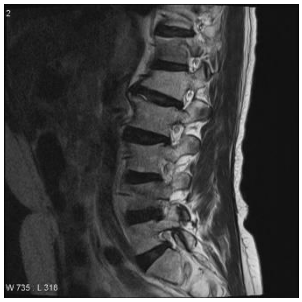
# Are Low Back Pain CT Referrals from Family Physicians Concordant with the Choosing Wisely Recommendations?

Presenters: Gabrielle Logan (glogan@mun.ca) & Dr. Amanda Hall from Memorial University of Newfoundland

## Goal



Choosing Wisely recommends decreasing lumbar spine CTs. They recommend lumbar spine CTs should be ordered only when red flags are present.

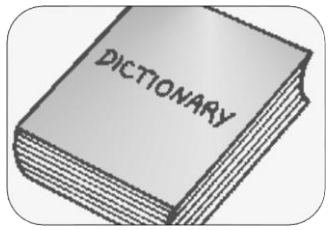
We wanted to know if family physicians in one health region in Newfoundland and Labrador were ordering appropriately according to these recommendations.

## Challenges


Data Quality

Incomplete Treatment History

Data Access

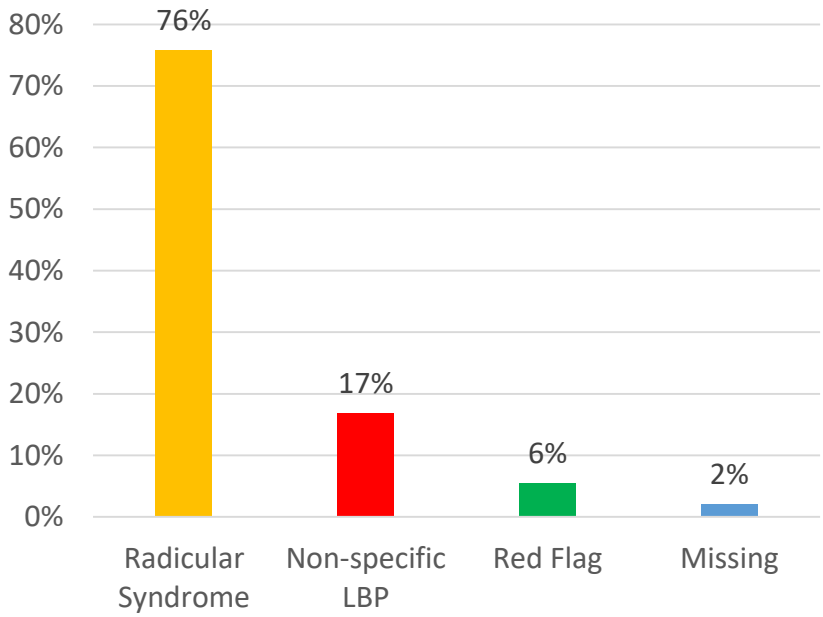



Definition of Appropriateness

## Lesson Learned

Out of 3,596 referrals, the vast majority of CTs were ordered for patients with symptoms of radicular syndrome (sciatica, spinal stenosis, radiating pain in legs, radiculopathy).

There is evidence from the referrals that sometimes patients are requesting imaging.




Why are so many CTs being ordered for patients with radicular syndrome?

# Optimizing the Use of Endoscopy for Young, Otherwise Healthy Patients with Dyspepsia

Physician Learning Program

Brenna Murray[1], Jennifer Halasz[2], Kelly Burak[1,2], Shawn Dowling[1,2], Tarun Misra[2], Jennifer Williams[2], Mark Swain[2], Gilaad Kaplan[2], Linda Slocombe[3], Kerri Novak[2]
[1]University of Calgary, Physician Learning Program; [2] Calgary Division of Gastroenterology and Hepatology; [3] Primary Care Networks

## Dyspepsia...

occurs in 20% of adults

**Symptoms include:**

- belly pain
- bloating
- nausea
- heartburn
- loss of appetite

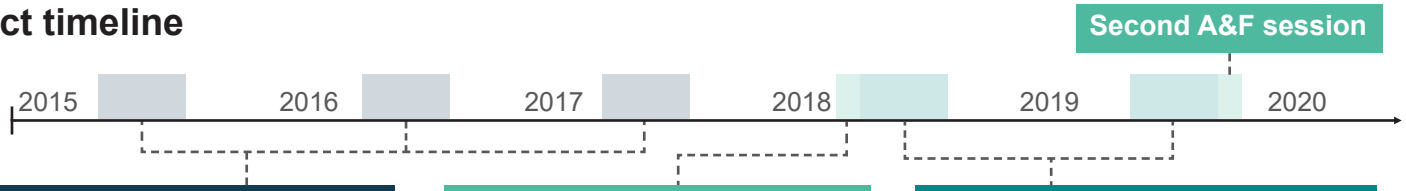
Choosing Wisely Canada advises against the use of esophagogastroduodenoscopy (EGD) in dyspeptic patients less than 55 years without alarm symptoms as clinically significant findings are rare.[1]

## Project Goals

- Encourage self-reflection on individual physician practice to optimize EGD usage.
- Align practice with the current standards.
- Provide individual and peer comparator data reports on low yield EGDs.
- Facilitate group discussion on barriers and faciltiators to changing practice.

1 - Choosing Wisely Canada. Canadian Association of Gastroenterology. Five Things Physicians and Patients Should Question 2017. https://choosingwiselycanada.org/gastroenterology/. Accessed March 29, 2019

## Project timeline




April 1 to June 30, 2015 - 2017
**Low yield EGDs identified using administrative data and expert input**

March 2018
**Individual data reports and audit & feedback session**

2018 - 2019
**Data re-pull and develop education materials to guide appropriate resource utilization**

Co-designing the program with GI physicians and champions strengthened the criteria for low yield EGDs and aligned the report content with physician needs.

Including family physicians and patients perspectives would be valuable to the group discussion.

Data will be re-pulled from a 3-month period in 2018 and 2019. We are also developing education materials for physicians and patients to guide appropriate resource utilization.

A second audit & feedback session is planned for Fall 2019.

## Analysis and Outcomes

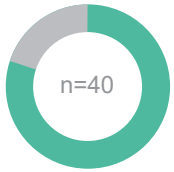
= 19.5 patients

**Of 1358 EGDs performed to investigate dyspepsia in patients less than 55 years of age..**

**514 (38%) were found to be low yield (the patient had no red flags)**
Data analysis identified significant practice variation (IQR 20% - 50%)

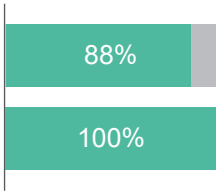
**10 of those 514 patients (1.9%) had signficant findings, none of which were malignancies**

GI physician champions shared their data to stimulate discussion and coached peers towards practice change. Participants shared that patient expectations and fears of serious conditions being missed influenced their decision to use an EGD.




**80% of GI physicians consented to receive a report**

**Of the evaluations we received:**




88% agreed the report helped reflect on their practice

100% agreed the information was helpful; the peer comparator was useful

# Opioid Crisis! Standardization of Prescriptions to Decrease Excess Opioids After Simple Laparoscopic Surgery

**Presenter:** Jenny Chiu (jenny.chiu@nygh.on.ca), **Principal Investigator:** Dr. Sanjho Srikandarajah (sanjho.srikandarajah@nygh.on.ca)

***The aim of this study was to assess post discharge opioid consumption in patients undergoing laparoscopic appendectomy (LA) and laparoscopic cholecystectomy (LC) compared to the amount prescribed. This data would then be used to create a standardized evidenced-based prescription and patient education pamphlet that could be implemented at our centre following LA and LC surgeries. The primary outcome was the quantity of opioid medication prescribed and consumed. Secondary outcomes included patient satisfaction with analgesia and disposal methods for unused opioids.***

Discharge prescriptions were provided by the general surgery attending physicians and residents who were instructed to continue prescribing as they normally would

↓

Patients were called after discharge from hospital on post-operative day 7 and asked a standardized questionnaire by the investigators. Questions included: amount of prescribed opioids used, pain control, how pills were stored/disposed of. Patients were recruited from April to June 2017.

↓

The data obtained was analyzed.

↓

This data was used to create a standardized prescription.

↓

A patient information sheet was developed and used to counsel patients on opioid use and disposal, in partnership with the Institute for Safe Medication Practices (ISMP) Canada.

↓

Patients were re-recruited (Nov 2017- Jan 2018) after implementation of the standardized prescription. Questions included: the amount of prescribed opioids used, pain control, whether or not they received education about opioids and storage and/or disposal.

| Characteristics | Prior to Introduction of Standardized Prescription | After Introduction of Standardized Prescription |
|---|---|---|
| Number of Patients Recruited | 129 (33 LA and 94 LC) | 109 (11 LA and 98 LC) |
| Number of Pills Prescribed | 2672 | 1182 |
| Percentage of Pills Consumed | 17% | 20% |
| Average Number of Pills Consumed | 3.6 pills | 2 pills |
| Percentage of Patients who Received Education on Opioids | 8.5% | 44% |
| Average Pain Scores (out of 10) | 3.87 | 3.85 |
| Average Satisfaction Scores (out of 5) | 4.4 | 4.4 |

1. acetaminophen (Tylenol® extra strength) 500 mg PO Q6H x 3 days
2. ibuprofen (Advil® regular strength) 200 mg PO Q6H x 3 days
3. Choice of Opioids: (MD selects one)
   - morphine 5 mg Q4H PO PRN for severe pain,
     Mitte: 20 tablets; Dispense 10 tabs every 3 days
     OR
   - HYDROmorphone 1 mg PO Q4H PRN or severe pain,
     Mitte: 20 tablets; Dispense 10 tabs every 3 days

Prescription expires after 1 month



**Over 3 months, only 1,182 tablets prescribed (vs. 2672 previously) with standardized prescription:**

**56% LESS than previous!!!**

**Tips for successful implementation:**

- Collaboration is key – engage all the key stakeholders to develop standardized prescription based on patient population and practices as well as staff for implementation/rollout of prescription and patient education
- Leverage technology – e.g. order sets for prescriptions (or use preprinted orders in non-CPOE environment)
- Engage patients – education and setting expectations for pain management

**Resources:**

- Patient info sheet:
  - https://www.ismp-canada.org/download/OpioidStewardship/OpioidsAfterSurgery-EN.pdf
- Opioid Prescribing:
  - https://opioidprescribing.info/
  - http://www.breecollaborative.org/wp-content/uploads/WHA-Bree-Opioid-Provider-Fact-Sheet.pdf

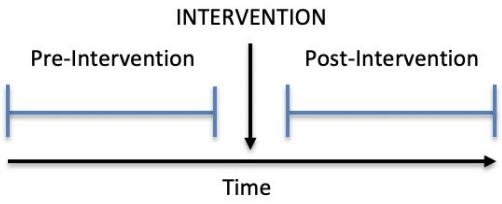
*Dr. Luke Hartford, MD DVM*
*Dr. Julie Ann Van Koughnett, MD MEd FRCSC FACS*
*Division of General Surgery, Department of Surgery*

# The Standardization of Outpatient Procedure (STOP) Narcotics: A prospective non-inferiority study to reduce opioid use in outpatient general surgical procedures

**Background:**

- Prescription opioids have a major role in opioid misuse
- Risks of persistent opioid use after surgery is 5-15%
- There are variable, excessive and unused opioid prescriptions in surgery

**Methods:**




| Inclusion Criteria |
|---|
| Age 18-75 years |
| OUTPATIENT procedures |
| Laparoscopic Cholecystectomy |
| Open Ventral/Umbilical Hernia |
| Open Inguinal Hernia |
| Anorectal Surgery |
| Breast Surgery |

| Exclusion Criteria |
|---|
| Allergy/intolerance to NSAIDs |
| Chronic pain conditions |
| Regular use of opioids |
| Substance abuse disorder |
| Chronic kidney disease |
| Active peptic ulcer disease |
| Cirrhosis |

| INTERVENTION |
|---|
| Patient education<br>• Expectations<br>• Instructions |
| Provider education<br>• Physician and nursing |
| Intraoperative pain management<br>• Dexamethasone<br>• Ketorolac<br>• Ondansetron |
| Post-operative pain management<br>• NSAIDs<br>• Acetaminophen<br>• "Rescue" opioid prescriptions |

**Results:**

| All groups: Pre-intervention (351) vs. Post-intervention (331) | | |
|---|---|---|
| Average pain in first 7 days (1-10) | *2.3 v. 2.2* | ***Equivalent pain control*** |
| Patient rated quality of pain | *71% v. 82%* | ***Satisfied patients*** |
| OME (median) | *100 v. 50* | ***50% reduction in opioid prescribing*** |
| Number of pills prescribed (median) | *20 v. 10* | ***50% reduction in opioid prescribing*** |
| Narcotic prescription filled (%) | *79% v. 45%* | ***Only 45% filled opioid prescription*** |
| Prescription refills (%) | *5% v. 3%* | ***No difference in refills*** |
| Appropriate medication disposal (%) | *8% v. 20%* | ***Increased medication disposal*** |

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