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| **Question**  ***[Responder]*** | **Response** |
| Request for reference referred to on Slide 6, Laboratory Connection to Diagnostic Error (as noted at bottom of Slide: Reference: CLN 2012; 38:17 - Clinical Laboratory Integration into Healthcare Collaborative Centre for Disease Control and Prevention)  ***[Phillip Morehouse]*** | **Available online @**  [http://www.aacc.org/publications/cln/2012/September/Pages/TestUtilization.aspx#](http://www.aacc.org/publications/cln/2012/September/Pages/TestUtilization.aspx)  **Phillip has suggested this additional reference for related information:**  **Society to Improve Diagnosis in Medicine at** [**www.improvediagnosis.org**](http://www.improvediagnosis.org) |
| Request for Reference that Phillip referred to at Slide 30, Systematic, Multi-Initiative Strategy for Improving Diagnostic Service Utilization (Institute of Medicine)  ***[Phillip Morehouse]*** | **Best Care at Lower Cost: The Path to Continuously Learning Healthcare in America. Sept 6, 2012. Institute of Medicine.**  **Available online @** [**http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx**](http://www.iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx) |
| A list of references | **See above.** |
| Presentation and Knowledge Transfer package (Phillip) | **Updated KT (Knowledge Transfer) Package provided for download at end of webinar. Also sent as separate file attachment to Webinar follow-up e-mail.**  **Presentation available via archived session; see** [https://arkadinoneplace-nm.adobeconnect.com/\_a1008264557/p92ifov48rx/?launcher=false&fcsContent=true&pbMode=normal](https://exchange.gnb.ca/owa/,DanaInfo=gnbowa2.gnb.ca,SSL+redir.aspx?C=21ca2ec4c27a4b628bc6ebdc2ecd7ede&URL=https%3a%2f%2farkadinoneplace-nm.adobeconnect.com%2f_a1008264557%2fp92ifov48rx%2f%3flauncher%3dfalse%26fcsContent%3dtrue%26pbMode%3dnormal) |
| Is there a restriction to test menus at smaller sites in Cape Breton District Health Authority?  ***[Phillip Morehouse]*** | **No, if the test is not performed at the site, it is performed through a referral process.** |
| If you had to choose one test to start with, what would it be?  ***[Phillip Morehouse]*** | **For our process, ESR, PSA, CEA and Throat Swabs showed significant reductions, therefore proving these approaches are worthwhile to the organization.** |
| Has there been study/ review re sustainability of what you are doing?  ***[Phillip Morehouse]*** | **See slide #25. We spend <15 hours for each test including ongoing monitoring at 3 month intervals. Very few tests have rebounded and our plan is to run them back through the process.** |
| Most of your approach so far has been educational in nature- trying to change physician’s practice. Have you considered/ used other approaches such as restricting tests to particular groups of practitioners, or automatically cancelling tests that do not meet the pre-defined criteria?  ***[Phillip Morehouse]*** | **The lab automatically cancels FT4 orders for normal TSHs, unless specific clinical reasons are given.**  **Many testing algorithms are emerging. Check Mayo Medical Laboratories as a resource of evidence-based algorithms.** |
| Do you use automatic order entry control for utilization orders, for tests outside the guidelines?  ***[Phillip Morehouse]*** | **No, not currently possible for our provincial system.** |
| What do you think about efficiencies gained through centralized labs?  ***[Phillip Morehouse]*** | **If you have a high quality/efficient central lab, a good transportation system and a good LIS, this can work very well as long as turnaround time requirements can be met. Ongoing communication with Physicians at the site can be an issue, in my experience, resulting in increase testing.** |
| Where do you start or who do you go to in order to get the changes that are required?  I feel that I am a small part of the puzzle and would not have much pull to get this done.  ***[Phillip Morehouse]*** | **Start by engaging your Medical Director, VP Medicine and CEO in this problem. Pick a simple intervention and measure the results.** |
| CADTH – could you spearhead a pan Canadian team to develop a pan Canadian laboratory menu/guidelines, etc. ?  ***[Sumeet Singh]*** | **Under its current mandate and funding for the assessment of non-drug health technologies, CADTH is able to develop evidence-based reviews and optimal use recommendations for a number of lab tests each year and also help connect laboratory service decision-makers with existing high-quality assessments of tests as appropriate.**  **CADTH’s recommendations are designed to help with decision-making surrounding funding, policy or procurement, and can also form the basis for educational and other interventions aimed at increasing alignment between clinical practice and evidence. We’re careful to distinguish ourselves from clinical practice guidelines, which differ in a number of important ways from CADTH’s recommendations: they are normally clinician-led, address numerous or all aspects relevant to the care pathway for a particular condition or patient population, and often do not consider cost/cost effectiveness or implementation issues from a system perspective.  For these reasons and because of the resources required for such an endeavour, development of a comprehensive lab menu or set of guidelines is likely out of scope for CADTH’s current program on lab tests. However, CADTH’s reviews and recommendations can certainly provide evidence and guidance in support of such initiatives regardless of whether they are occurring at the pan-Canadian, provincial/territorial, or local level. We would welcome the opportunity to engage with the groups or individuals involved to learn how we can help.** |
| Are you aware of any National data bases on utilization of lab services?  ***[Phillip Morehouse]*** | **Not that I am aware of, no; however we often access ordering guidelines from the Ontario Association of Medical Laboratories (OAML), British Columbia Medical Association’s Guidelines and Protocol Advisory Committee and others.** |
| Can you share the criteria you used to decrease ESR utilization?  ***[Phillip Morehouse]*** | **We used a guideline from OAML- Guideline for Ordering of Erythrocyte Sedimentation Rate (ESR).** |
| In NB we are interested to implement some changes such as repeat test interval restrictions, but the implementation is challenging due to busy IT/admin staff having time and resources to make them happen. Any suggestion how to free up resources to make these changes happen.  ***[Phillip Morehouse]*** | **Engage your senior management team in the issue. If it’s difficult for them to understand the impact, give them examples of the repeat testing and estimate the impact of the system in terms of reagent costs and time. Then, ask them to prioritize IT resources to assist.** |
| Are you planning on any interventions or education delivered directly to public?  ***[Phillip Morehouse]*** | **We ran a project with physician’s offices a few years ago where we merged the EMR with the cytology database to identify a target group to receive reminder letters around pap testing.**  **We have no other projects of this nature planned at this time, but we have lots of ideas.** |
| How do you gate keep expensive genetic tests when your hospital does not even have a team of experts to oversee the ordering of these tests.  ***[Phillip Morehouse]*** | **Everyone is asking this same question. The test and the treatment will be very expensive. Perhaps clear evidence- based ordering guidelines and tight control on who can order these very expensive tests.** |

For additional questions or comments related to Phillip’s content, please contact Phillip Morehouse at [morehousep@cbdha.nshealth.ca](mailto:morehousep@cbdha.nshealth.ca).