



OPTIMIZING CLINICAL PRACTICE

IMPROVING CHOICES

April 8, 2013

The Quebec government can save approximately 5 billion dollars by eliminating overdiagnosis and overtreatment at every level of the healthcare system.

Optimizing Clinical Practice: Improving Choices

Preface

Why is the Quebec Medical Association interested in this issue? For several years, the QMA has made efforts to identify, analyze and share innovative methods of medical organization from both local and international sources.

For this reason, the QMA is constantly seeking innovative methods that can lead to constant improvement in the quality of healthcare services.

Our current economic situation, which is characterized by increasing strain on public finances, calls for a fundamental reflection on the ways in which we can optimize clinical practice in order to improve the healthcare system's efficiency and performativity.

This document aims to set in motion systematic action that is structured to promote revision of our methods. The Quebec Medical Association is calling not only on the medical profession, but on all healthcare professionals, network managers, and anyone who uses the healthcare system.

It is time to improve our efficiency and concentrate on useful, relevant clinical practices. The QMA intends to play its part and take decisive leadership on this issue.

Performance

There is no shortage of studies and analyses of the performance of our healthcare system. The most recent of these tell us what we already know: the government is investing increasing amounts of money in the healthcare system, but various indicators tell us that Canadians are not getting what they're paying for.

The Center for Productivity and Prosperity (HEC Montréal)'s 2012 survey of Quebec emphasized that despite the money being invested into the healthcare system, frequent gaps in coverage, long wait times and a lack of physical resources were common.

In its 2012 *Health at a Glance* report, the Conference Board of Canada gave the Canadian healthcare system a B and ranked it 10th out of 17 countries.

The Task Force on the Funding of the Health System (Castonguay committee) reported that, overall, people were satisfied or very satisfied with the services they received, once they received them. However, it emphasized that the people of Quebec had less access to care than people in other provinces. In terms of productivity, the Quebec healthcare system is performing poorly compared to many other systems.

Budgetary outlook

Federal transfers

On December 19, 2011, the federal government announced changes to the funding of the main transfer programs. These changes will result in a decrease in federal funding to provincial and territorial healthcare and other social programs.

The main changes are as follows:

- A reduction in the Canada Health Transfer (CHT) growth rate (from 6% to the nominal GDP growth rate) starting in 2017-2018;
- A change to per-capita cash payments for the CHT in 2014-2015, along with some limited protection which is accorded to the poorest provinces;
- A continued cap on the equalization program until at least 2018-2019.

Even if the various governments do not agree on the precise impact of these changes, it is clear that Quebec will receive less funding than if the methodology used since 2004 were maintained. The impact of these changes will be felt twice over: once in 2014-2015, due to changes in the payment formula, and a second time in 2017-2018 when the decreased growth rate is applied.

As a result, healthcare establishments and providers will be under a lot of pressure to change their ways of doing things in order to improve the performance and efficiency of the system.

Two major options

The government has a choice of two paths, which are not mutually exclusive.

The first option involves focusing on measures that will grant **better control** over the main spending categories: institutional budgets, doctors' salaries and medications. This control will necessarily result in a rationing of services.

This is the path the current government seems to want to take, at least according to the 2013-2014 allocations (filed in March), as well as certain statements by the Ministry.

Three measures stand out:

- Increasing the health and social services establishment allocation by 4.3%, a significantly lower percentage increase than in previous years.
- Eliminating the "15-year rule" for name-brand medications, accompanied by a substantial increase in tax credits for pharmaceutical research.
- The publicly expressed desire of the Ministry to review the terms of the latest agreements (by staggering the raises over a longer period of time) they signed with the medical federations.

The second avenue that could be taken involves targeting inefficiency. According to the Institute for Healthcare Improvement, waste of all types comprised at least 20% of all healthcare expenses in the United States.

There is no reason to believe that the situation is much different on this side of the border. Even though 20% is considered a conservative estimate in the US, when applied proportionally to Quebec it equates to over 5 billion dollars, excluding the medical services budget. Of course, given the structural difference between the American (public and private) and Canadian healthcare systems, comparisons must be analyzed carefully. But all indicators say that poor use of resources is not a uniquely American problem.

Overtreatment, gaps in healthcare coordination, nosocomial infections, medication errors, preventable incidents, readmissions, etc. How can doctors, along with other healthcare professionals, reduce or even eliminate these types of waste, which threaten the sustainability of our system? This is what the QMA wants to explore, first by providing an overview of the situation, then by taking action.

The costs of non-quality

According to the literature

In Canada, studies attempting to evaluate the costs of non-quality are infrequent and piecemeal, while the field of study is vast and fragmented. In a recent technical report¹ from the Canadian Patient Safety Institute, we find the following:

We calculated a preliminary estimate of the economic burden of adverse events in Canada in 2009–2010 was \$1,071,983,610 (\$1.1 billion), including \$396,633,936 (\$397 million) for preventable adverse events. This estimate does not include the direct costs of care after hospital discharge, or societal costs of illness, such as loss of functional status or occupational productivity.

Note that this report only focuses on adverse events, and covers a short timeframe. Knowing that Canada's total healthcare costs are around \$207 billion, we can confirm without a shadow of a doubt that the amount expressed in this report vastly underestimates the cost of non-quality, given that it only amounts to 0.2% of the total, which would be the envy of even the best service sectors in the world.

Preventable adverse effects are just one element of non-quality. Other elements, such as non-pertinence and poor execution of processes, must also be taken into consideration. Total non-quality could be described as:

- "Doing or causing something inefficient or useless, poorly execute it and obtain poor or even harmful results."

¹ The Economics of Patient Safety in Acute Care, Technical Report
<http://www.patientsafetyinstitute.ca/en/toolsResources/Research/commissionedResearch/EconomicsofPatientSafety/ Documents/Economics%20of%20Patient%20Safety%20-%20Acute%20Care%20-%20Final%20Report.pdf#search=economics%20of%20patient%20safety>

Studies of the American healthcare system shed a more complete light on the situation. Recently, the prestigious publication *Health Affairs*² published a striking summary³ with the following as a main question:

"A third or more of what the US spends annually may be wasteful. How much could be pared back—and how—is a key question."

The classification used to describe the different categories of useless or avoidable spending, and thus non-quality, is original and innovative. It is worth studying in order to better define the vast scope of non-quality.

- **Failures of care delivery.** This category includes poor execution or lack of widespread adoption of best practices, such as effective preventive care practices or patient safety best practices. Delivery failures can result in patient injuries, poor clinical outcomes, and higher costs.
- **Failures of care coordination.** These problems occur when patients experience care that is fragmented and non-continuous—for example, when the care of patients transitioning from one point of care to another is poorly managed. These problems can include unnecessary hospital readmissions, avoidable complications, and declines in functional health status, especially for the chronically ill.
- **"Overtreatment."** This category includes dated treatments that are given according to providers' preferences rather than those of informed patients, as well as treatments which are not scientifically based or those motivated by considerations other than provision of optimal care for a patient.
- **Administrative complexity.** This category consists of excessive spending generated by inefficient or imperfect rules and overly bureaucratic procedures on the part of private health insurance companies, the government, or accreditation agencies (such as the CNESST). For example, the absence of standardized forms

² Robert Wood Johnson Foundation

³ Health Policy Brief, December 13, 2012

http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf403314

and procedures can result in needlessly complex and time-consuming work for physicians and their staff.

- **Pricing failures.** This type of waste (more present in the USA but also exists in Canada) occurs when the price of a service exceeds that found in an adequately functioning market, where a reasonable profit is calculated using the real cost of production. (The report cites medical imaging as an example – prices are artificially high due to an absence of transparency or healthy competition.)

Estimation of losses in healthcare spending in the USA in 2011, by category			
	Total costs for the American healthcare system (in \$billions)		
	Low estimate	Median estimate	High estimate
Failures of care delivery	102	128	154
Failures of care coordination	25	35	45
"Overtreatment"	158	192	226
Administrative complexity	107	248	389
Pricing failures	84	131	178
Total	476	734	992
%	18%	27%	37%

Although American healthcare losses are more significant, applying these numbers to the situation in Quebec can give us an idea of the sums involved. In the 2013-2014 year in Quebec, the five categories of useless or avoidable expenditures add up as follows:

Estimation of losses in healthcare spending in Quebec in 2013-2014			
	Total costs to the Quebec healthcare system, excluding the medical services budget (based on a budget of \$26.3 billion)		
	Low estimate	Median estimate	High estimate
Total	\$4.7 billion	\$8.5 billion	\$11.7 billion
%	18%	27%	37%

Some would say that since there are major structural differences between the American (public and private) and Québécois healthcare systems, especially in terms of funding, comparisons are bound to be flawed. This is no doubt true. But the similarities in clinical practices on both sides of the border are enough for us to consider this issue here as well. Even if the potential gains to efficiency are not as high as 4.7 million dollars, they do

exist and they are worthy of attention.

Non-quality in the healthcare sector is a constant, yet hidden, concern. Essentially, medicine—in the broader sense of healthcare services—is believed to be of much higher quality than it actually is.

Another exhaustive American study⁴ by the Wharton School of Business at the University of Pennsylvania in Philadelphia analyzed 37.6 million admissions files. A large part of the study focused on complications. It showed us that the complications:

- *account for more than 30% of hospitalized patients and 25% of outpatients;*
- *cause 10 to 12% of all deaths;*
- *increase the number of outpatient resources from 3.5 to 4.0 consultations;*
- *are the reason for 20 to 25% of all hospital admissions;*
- *are the reason for 24 to 30% of avoidable costs (\$16M USD⁵/10,000 admissions);*
- *are the reason for 14 to 30% of hospital stays;*
- *have effects that can range from negligible (39.5% of complications, \$1,091 USD) to catastrophic (4.5% of complications, \$27,324 USD) and have an average incremental cost of \$311 USD).*

But how did we arrive at such a position? Decision-making and the execution of those decisions are the two biggest sources of non-quality.

⁴ Brailer David, et al. *Complication Risk: A New Measure of Outcome Quality, Medical Care, May 1996*

⁵ Mid-'90s

Decision-making

Every five years, the amount of available medical information—comprised of patient data—doubles.

The literature reveals that barely 20% of medical knowledge is based on convincing data. As a result, 20% of diagnoses are incorrect and 1.5 million medication errors occur in the United States each year.

The field of medical knowledge is already too vast for the human brain to comprehend, so doctors are required to use diagnostic aids and stop believing that proper diagnosis is an art in which intuition has a role to play. But it is often difficult to make a good diagnosis, because the accessible data is all too often unstructured.

Each patient describes their health problems differently. And each doctor has their own way of filling out a questionnaire or conducting an examination. There are so many variations in different practices that quality in that sense simply isn't possible. In the quality sector, it is well-known that quality is inversely proportional to the number of variations in practices and processes. It is therefore significant that IBM is investing a lot of energy into developing a diagnostic aid: Watson. This approach is similar to that used to beat chess grandmasters and Jeopardy champions.

We feed the supercomputer words, sentences, expressions, types of answers, descriptions of physical examinations, diagnostic techniques, imaging and lab results that could be associated with a diagnosis. The tireless computer then analyzes this data (structured or unstructured) and suggests and explains hypothetical diagnoses to a doctor. The final decision is up to the doctor. Obviously, this process means that there are fewer variations in data analysis, leading to a higher-quality diagnosis or therapeutic approach to be pursued.

Large variations in clinical decision-making lead to non-standardized use of diagnostic examinations or certain treatments, and hence non-pertinence. In such circumstances, the doctor should be wondering "How will information obtained in an imaging or lab test impact my decision?" How many patients are prescribed a diagnostic test with low sensitivity or specificity (positive or negative predictive value), taking into account their health and risk factors (for example, an ECG stress test for a 30-year-old woman who

has chest pain or a brain scan for an elderly, hospitalized patient who has difficulty waking up after receiving a new sleeping pill the night before)? How many imaging tests are simply fishing expeditions?

However, when considering reducing the demand for certain tests or examinations in some situations, it is important to consider risk management. Although it is known that some tests may, in some cases, come with some risks to the patient, not performing certain tests or examinations can also be detrimental to the patient.

Doctors must therefore exercise clinical judgement, accounting for convincing data that dictate the advisability of tests and exams.

Processes for providing care and treatments

The same type of variations or lack of standardization can be observed in the processes established for executing tasks. In November 1999, the Institute for Healthcare Improvement released a report, *To Err is Human*, which revealed that 44,000–98,000 deaths per year in American hospitals were due to medical error. Depending on the number used, this places medical error between the 5th and 9th leading causes of death.

Experts⁶ believe that one of the reasons is that the quality control mechanisms in place for healthcare systems are in a world apart from other quality control systems. Medical education is an age-old tradition that is seen as an art, more than a science. Since the

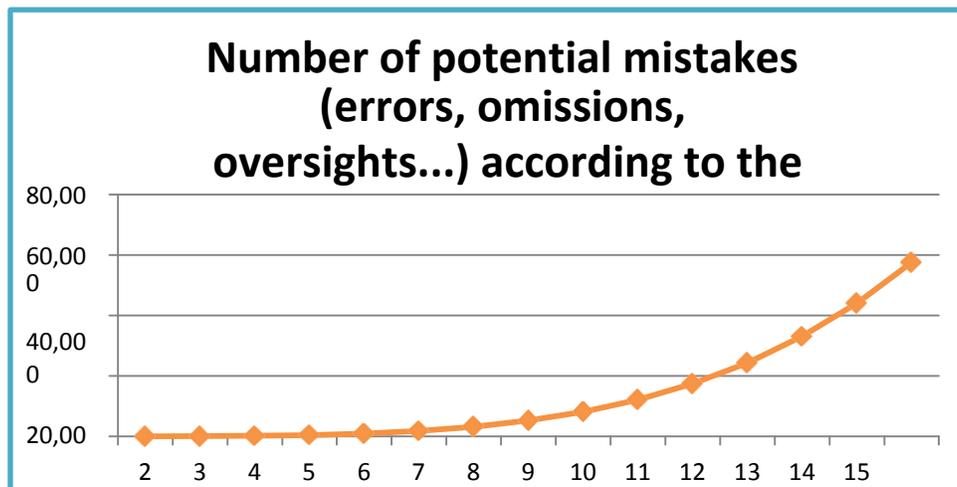
⁶ The Past, Present and Future of Health Care Quality. Urgent need for innovative, external review processes to protect patients, Martin D. Merry, MD, & Michael G. Crago, PhD, *The Physician Executive*, September – October 2001.

1980s, there has been an increasing pressure to introduce science-based total quality techniques.

A telling example: observe the probability of error in relation to the number of steps in a process and the quality control measures in place to detect errors in these processes.

The risk of potential defects (D) increases drastically with the number of steps (N) in a process.²

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From this, we can see that if a process has 16 steps (not uncommon in healthcare), there are 57,600 potential faults.

Quality control mechanisms in the production of goods and services are, rightfully, trying to prevent risks and detect mistakes. For example, look at the Six Sigma scale (from 1 to 6): A system with a quality rating of Sigma 2 has 308,000 mistakes per 1 million events (one step of a process is considered an event). Sigma 3 = 62,800; Sigma 4 = 6,210; Sigma 5 = 230 and Sigma 6 = 3.

Number of steps	Risk of potential mistakes	Number of mistakes per number of steps				
		Sigma 2	Sigma 3	Sigma 4	Sigma 5	Sigma 6
2	4	1.2	0.3	0.0	0.0	0.0
3	36	11.1	2.4	0.2	0.0	0.0
4	144	44.4	9.6	0.9	0.0	0.0
5	400	123.2	26.7	2.5	0.1	0.0
6	900	277.2	60.1	5.6	0.2	0.0
7	1,764	543.3	117.8	11.0	0.4	0.0
8	3,136	965.9	209.5	19.5	0.7	0.0
9	5,184	1,596.7	346.3	32.2	1.2	0.0
10	8,100	2,494.8	541.1	50.3	1.9	0.0
11	12,100	3,726.8	808.3	75.1	2.8	0.0
12	17,424	5,366.6	1,163.9	108.2	4.0	0.1
13	24,336	7,495.5	1,625.6	151.1	5.6	0.1
14	33,124	10,202.2	2,212.7	205.7	7.6	0.1
15	44,100	13,582.8	2,945.9	273.9	10.1	0.1
16	57,600	17,740.8	3,847.7	357.7	13.2	0.2

The aviation industry is (fortunately) rated at Sigma 6. In 2012, there were no deaths in the American civil aviation industry. Meanwhile, the healthcare sector fluctuates between Sigma 2 and Sigma 4. Anesthesia is the notable exception; it is near a Sigma 6. No other service sector has similar results because, if it did, it would be destined to disappear.

The costs associated with non-quality, not only in money but in human suffering, are staggering. For that reason, the predicted costs outlined in the American study are surely not too far off.

Concerted efforts are needed to attack the problem of non-quality in the healthcare sector. Everybody will need to take action, because the healthcare sector is so vast and complex.

What is being done elsewhere

With this concerning evidence, the QMA has been interested in several recent, extremely promising initiatives that are attempting to target sources of inefficiency and highlight strategies that prioritize clinical practices based on relevancy and convincing data. Here, we will outline three projects.

Choosing Wisely⁷

The Choosing Wisely program is an initiative from the ABIM Foundation. It is undoubtedly the boldest and most thorough project of its kind. Its aim is to eliminate useless or irrelevant examinations and treatments.

No less than 26 national groups of American specialists, which represent some 500,000 doctors, took action. The program emphasizes an incentive approach, based on communication between doctor and patient. Each specialty identified five current tests or examinations that could be avoided because they bring few benefits.

Using this approach, the Choosing Wisely program hopes to eliminate useless or irrelevant tests, examinations and treatments. Each list provides information based on convincing data on situations where these tests may be appropriate.

Because they recognize that patients need to be better informed about the care they actually need, Choosing Wisely is also collaborating with Consumer Reports to provide accessible information to the general public.

Closer to home: Alberta's initiative

Healthcare in Alberta is currently undergoing considerable restructuring due to the introduction of strategic clinical networks (SCNs).⁸

⁷ ABIM Foundation. 2013. Choosing Wisely. *Five Things Physicians and Patients Should Question*. Online: www.choosingwisely.org

⁸ Alberta Health Services. August 2012. Strategic Clinical Networks: A Primer & Working Document. Online: www.albertahealthservices.ca/scn.asp

Tom Noseworthy, critical care physician and Associate Chief Medical Adviser for Alberta Health Services, is heading the restructuring efforts.

The SCNs' mandate is to concentrate on provincial strategy and clinical performance in the hopes of providing high-quality healthcare at a reasonable price. The SCNs prioritize convincing data (evidence-informed improvements) for prevention and clinical performance in order to obtain the best quality and results at a reasonable price.

SCNs are formal structures composed of interdisciplinary groups that have a province-wide reach and a mandate to conceive and recommend improvement plans. These improvement plans will provide measurable, sustainable improvement targets for clinical and operational processes in Alberta's healthcare network. They will integrate research initiatives and knowledge translation activities in order to improve well-being for people of all ages.

The SCN program intends to ensure that primary care networks and family care clinics are accessible (i.e. located where patients live). Doing so will require engagement from primary healthcare directors across the province in order to establish a seamless system.

Definition of performance: In 2011, AHS organized a series of three symposiums, supported by the Institute of Health Economics, to determine the characteristics of the most effective healthcare systems in the world. Twenty characteristics were determined; they serve as the basis for AHS' actions.

Definition of quality: The Health Quality Council of Alberta (HQCA) published an inclusive quality matrix that covered six dimensions approved by the province: acceptability, accessibility, appropriateness, effectiveness, efficiency and safety. Each dimension has a specific definition that can inform the development of SCN indicators and success parameters.

AHS has come up with a plan for the development and implementation of SCNs. SCNs are organized around key strategic sectors that cut across groups of patients. These areas have been identified as having the most needs and the greatest number of illnesses. Their clinical practices are also most in need of improvement. In the first step,

six areas were developed in 2012: mental health, addiction, cancer, diabetes, obesity and nutrition. In the fall of 2012, population health, health promotion, primary care and chronic illness management were added and integrated into the existing SCNs. Finally, in the spring of 2013, six new SCNs will be integrated:

- Complex Medicine: respiratory, renal, gastro-intestinal and other medical specialties
- Neurological Disease, ORL and Ophthalmology
- Maternal Health
- Newborn, Child and Youth
- Public Health and Health Promotion
- Primary Care and Chronic Illnesses Management

AHS recognizes that clinicians, especially doctors, must be placed in key strategic roles throughout the organization. They are not only front-line leaders; they must also direct the implementation of preventative and quality care strategies in the province.

The structure of SCNs should involve a dual leadership, composed of a vice-president (who will not have an operational role) and a medical director who has an active clinical practice. This leadership will function with a core group of members (Chief Zone Officers, Directors of Clinical Services and front-line clinicians) and be supported by a team of experts and counsellors.

Using a collaborative practice model, each SCN will be tasked with promoting a transparent approach with primary, specialized, acute and community healthcare teams in order to make each patient a priority.

Health Care Innovation Working Group

In the wake of the federal government's disengagement from the healthcare sector, the Council of the Federation launched a working group on healthcare innovation. This working group is composed of representatives of provincial and territorial governments, as well as representatives of healthcare professionals.

The CMA and QMA, which represent more than 80,000 members of the medical

profession, take part in this working group. In direct collaboration with various stakeholders, the CMA and QMA pilot projects that encourage the efficient and responsible use of healthcare funds and resources with the goal of improving the quality of patient services.

The working group has shown that interprovincial exchanges can lead to better practices for patients and contribute to significant savings for the healthcare system while fully respecting provincial jurisdictions.

The efforts of the working group have already begun to give concrete results; in particular, they have started to counter the effects of non-standardization in clinical processes and improved the relevancy of procedures.

Yet in January 2013, the government of Quebec chose to leave the working group. At a time when all Western governments are looking for ways to curb rising healthcare costs, it is somewhat surprising that Quebec alone in refusing to evaluate and consider better practices from other places. This "empty chair strategy" does not appear to be the best way to make our healthcare system more efficient.

And what about Quebec?

The Center for Interuniversity Research and Analysis of Organizations (CIRANO), in collaboration with the QMA, led an inquiry into certain medical practices in Quebec, including defensive medicine.

CIRANO had no data about the occurrence of this practice in Quebec, so they started preparatory work and quickly noted that fear of prosecution is not the only factor in defensive medicine. Above all, they saw that opinions were divided on whether this practice even existed in Quebec. An investigation into the subject proved to be wise.

The investigation covered the decision-making process for diagnostic tests, the demand for lab tests, the prescription of medications, as well as time spent with each patient and time filling out medical history, patient safety, quality of care and medical responsibility.

The results show that over the past five years, 24% of doctors surveyed have increased the number of examinations or lab tests requested for their patients.

To explain this "clinical behaviour," the doctors surveyed gave motives that could fall into several categories. Two of these categories were particularly significant to us. The first covered the following motives:

- Provision of better diagnoses
- Meeting standards of practice
- Issues relating to the increasing complexity of medicine
- At the suggestion of CPD programs
- Avoidance of useless therapies

Note that these five reasons had an average score that was higher than average, and address generalized norms which aim to provide better diagnoses for the benefit of patients. We can therefore accept these responses.

The second category covered the following motives:

- Meeting patients' expectations
- Increased accessibility of tests
- Fear of prosecution for malpractice

These three reasons confirm that a significant number of doctors have increased the number of requests for testing and examinations for potentially unjustified reasons. These requests have placed pressure on the system and are likely to engender avoidable expenses. The detailed analysis of the results of the inquiry will be completed soon and will be made public during the QMA's 2013 meeting on April 20, 2013.

Time to act

Given these facts, the medical profession can no longer remain indifferent.

The Quebec Medical Association is proposing a rigorous, concerted intervention strategy in the hopes of eliminating sources of waste.

The strategy will operate on three levels:

- Doctors and other healthcare professionals
- The general population
- The government

1. Doctors and other healthcare professionals

The Quebec Medical Association will launch a national working group that will be tasked with coordinating work to identify the sources of inappropriate resource use in the healthcare system. The group will also propose strategies to eliminate sources of waste.

Among other things, the working group will:

- Inventory current governing rules;
- Compile a digital report of the rules and ensure it is circulated;
- Inventory available clinical decision-making tools;
- Compile a digital report of the tools and ensure it is circulated;
- Propose strategies that will help doctors and other healthcare professionals coordinate healthcare interventions;

Next, the working group will identify five specialties or areas of activity (which should be able to produce short-term results) to analyze in depth. For each specialty, the working group will do the following:

- Review the evidence on the efficiency of the most frequently-prescribed interventions, tests or examinations.
- Identify interventions, tests or examinations that should not be performed under

certain circumstances.

- Identify clinical situations in which, according to the evidence, the interventions, tests and examinations would be appropriate.
- Propose strategies for concerned professionals to implement and circulate these methods.

Naturally, we will request the help of doctors in the specialties being studied in order to accomplish this task. Once the process has been thoroughly evaluated, this analysis may eventually be extended to all medical and surgical specialties.

2. General population

As mentioned before, the CIRANO inquiry showed that a significant percentage of doctors admitted that they were increasing the number of tests and examinations in order to meet patients' expectations.

It is clear that in the doctor-patient relationship, patients are able to influence doctors to prescribe tests or examinations which may not be necessary or even appropriate for the situation.

For that reason, any initiative that promotes rational use of tests or examinations by professionals must also be accompanied by an active public education campaign. Patients must be made to understand that this research on pertinence and quality isn't just trying to reduce the number of services, but rather promoting better use of resources by ordering tests and examinations only when needed.

The public education campaign should include user-friendly online and paper material that allows doctors to have a discussion with their patients without frustrating them. In order to accomplish this, alliances with patient groups or specialized national groups could be considered.

For example, the *Institut national d'excellence en santé et en services sociaux* (INESSS) has been given the responsibility of designing and launching an information centre for the general public. This information centre will gather clinical information so that patients can make informed, appropriate decisions about their care. The QMA will collaborate with INESSS in order to ensure that the project runs smoothly.

3. Government

Clearly, different government organizations must support this initiative.

The unwavering organizational and financial support of the Ministry of Health and Social Services (MSSS) will be essential. The *Régie de l'assurance maladie Québec* may be asked to collaborate in order to estimate the costs related to the clinical activities being studied. Finally, because of its mission to promote clinical excellence and efficient resource use in health and social services, INESSS may be asked to share its expertise in the QMA's project.

In collaboration with the QMA, AQESSS and other major professional organizations, the MSSS must be fully responsible for facilitating the project. They must establish structural elements that will allow for integration of the working group's efforts into its performance improvement strategies, as well as any future projects that may arise. They must also ensure the establishment of permanent regional committees, which will facilitate the application and incorporation of guidelines in clinical settings.

And once again, the MSSS, with the help of the Council of the Federation, must also incorporate the working group's findings on healthcare innovation.

As for the QMA, it will take the lead on a Quebec mission that will be an active participant at the first international Preventing Overdiagnosis Conference, which will take place in New Hampshire in 2013. The conference will be focused on one of the main causes of useless or avoidable expenditure: overdiagnosis. Representatives from England, the United States and Australia will be present to share initiatives for fighting overdiagnosis.

The QMA will have key representatives, who will help Quebec organizations rally around this important mission.

Conclusion

The Quebec Medical Association understands that this project is a truly colossal undertaking. It will require collaboration from stakeholders across all levels of our healthcare system.

Above all, the success of this project will depend on willing participation from all professionals and organizations involved in healthcare. Everyone, even the most traditional among us, must be willing to review their methods in order to eliminate unnecessary spending and reinvest the money saved in more appropriate, relevant processes.

This is how we will ensure the sustainability of our system for many years to come.