Choosing Wisely®: Applying the Campaign to Practice

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Chair, ACEP Board of Directors

Disclosure

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- Dr. Parker does not have a significant financial relationship to report.

Choosing Wisely®

- History
- The Story of Emergency Medicine and ACEP
- ACEP’s Recommendations
- Implementation efforts
The Cost of Care

- Cost of healthcare unaffordable
- U.S. spends 20X more compared to other countries
- Estimated 30% of spending wasteful
- Lack of communication between physician and patient one reason for waste
- Less waste, more resources for all

CTPA for Pulmonary Embolism

- ~2 million per year in U.S.
- 2012 CMS reimbursement ~ $446
- $446 X 2 million CTPA: ~ $892 million/year
- Est 33% CTPA done on low risk pretest probability
- $892 million X .33: ~ $300 million/year (savings)

Starting the conversation

- Piloted in 2009 by National Physician Alliance through Putting the Charter in to Practice grant
- List of “5 Things You Can do in Your Practice”
- 3 primary care specialties
- Published in Archives of Internal Medicine

The Campaign

- Sponsored by ABIM Foundation
- 9 Medical Societies in Feb 2012
- More than another dozen joined Feb 2013
- To date (April 2015) 65+ Medical Societies released at least one set
- 325+ recommendations
The Campaign

Choosing Wisely® aims to promote conversation between physician and patient by helping patients choose care that is:
- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Truly necessary

ACEP’s Journey

- ACEP initially declined participation in 2012
- ACEP Cost Effective Care Task Force (CEC) work extended
- In Feb 2013, after October 2012 ACEP Council discussion, review by an expert panel of EM physicians, the ACEP Board of Directors elected to participate using the CEC process
- Letter sent to ABIM Foundation and meeting occurred
- First 5 recommendations submitted June 2013 from CEC/Delphi panel process, released October 2013

Joining Choosing Wisely®

February 2013 ACEP Letter

Concerns included:
1. Unique nature of EM vs office-based care
2. Recommendations should have significant financial impact
3. Evidence-based care
4. Specialty-specific considerations
5. Explore liability-related reform/safe harbor
Development of ACEP CEC Strategies

- Board formed the CEC Task Force in 2012
- CEC TF debated the methodology to identify CEC strategies. Also debated whether to join Choosing Wisely®
- Survey sent to ACEP members
- 1,193 individual cost effective care suggestions submitted from survey.
- Delphi Panel formed to prioritize strategies.

Development of ACEP CEC Strategies

- Delphi Panel evaluated all proposed strategies utilizing three criteria
  1. Contribution to cost savings
  2. Risk/benefit to patients
  3. Actionability by emergency medicine providers
### Table: Measures and Votes

<table>
<thead>
<tr>
<th>Measure</th>
<th>Vote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't use urinary catheters for patient or staff convenience. We Will try to reduce the need for urinary catheters. Procedure 7</td>
<td>3</td>
</tr>
<tr>
<td>Don't order CT Pulmonary Angiography in low-pretest probability patients with suspected pulmonary embolism and a negative D-dimer (or no D-dimer performed). Imaging 4</td>
<td>5</td>
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<tr>
<td>Do non-invasive mechanical ventilation in adults with CHF with respiratory distress to reduce intubation. Procedure 8</td>
<td>7</td>
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<tr>
<td>Don't do CT head in adults with minor trauma outside of ACEP/CDC clinical policy recommendations. Imaging 7</td>
<td>9</td>
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<tr>
<td>Do use a checklist when inserting a central line. Procedure 3</td>
<td>10</td>
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<tr>
<td>Do not prescribe antibiotics in URIs in uncomplicated patients. Med/Blood 6</td>
<td>12</td>
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<tr>
<td>Don't order CT of the cervical spine in trauma patients who do not meet Canadian C-Spine Rule criteria. Imaging 8</td>
<td>13</td>
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<tr>
<td>Do not prescribe antibiotics routinely in sinusitis. Med/Blood 7</td>
<td>14</td>
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<tr>
<td>Do use techniques in ED to reduce ventilator associated pneumonia. Procedure 5</td>
<td>15</td>
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<tr>
<td>Do not continue futile resuscitative efforts. Procedure 4</td>
<td>16</td>
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<tr>
<td>Do use oral rehydration instead of IV for mild to moderate dehydration. Procedure 5</td>
<td>17</td>
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<tr>
<td>Don't do CT head in children with minor head injury who are low risk from PECARN studies. Imaging 8</td>
<td>18</td>
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<tr>
<td>Don't order any imaging for adults with atraumatic back pain without high risk features (needs to be defined: age &gt; 60, active cancer, ???) Imaging 8</td>
<td>19</td>
</tr>
<tr>
<td>Do use oral medications instead of IV whenever possible. Med/Blood 7</td>
<td>20</td>
</tr>
<tr>
<td>Do use a trial of oral disintegrating tablet (ODT) anti-emetic and PO hydration prior to intravenous fluids in uncomplicated cases of mild to moderate dehydration. Procedure 8</td>
<td>21</td>
</tr>
<tr>
<td>Don't give oral or IV antihypertensives to patients with isolated hypertension and no end organ damage. Med/Blood 7</td>
<td>22</td>
</tr>
<tr>
<td>Don't order urine cultures for healthy adult females with uncomplicated UTIs Labs 6</td>
<td>23</td>
</tr>
<tr>
<td>Don't do CT of the head in adult patients with syncope and a normal neurological exam. Imaging 6</td>
<td>24</td>
</tr>
</tbody>
</table>

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### Development of ACEP #1-5

- CEC Delphi Panel
- Multiple Conferences
- Analyzed existing pertinent literature
- Reviewed pertinent ACEP Clinical Policies
- 3 rounds of formal voting
- 12 strategies submitted to the Board
- Board picked the final 5 sent to Choosing Wisely®
- Released October 14, 2013

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### CEC Strategies are not Evidence-based Guidelines

But… Still May Help to Reduce Practice Variability

*Physician Variability in the Approach to a Given Clinical Condition*

In patients with a traumatic headaches, emergency physician ordering of CT ranged from 15-61% in a single ED practice.

Development of ACEP #6-10

- Member survey—cost effective and improve care.
- Delphi panel reconvened
- 12 strategies submitted to the Board
- Board picked the final 5 sent to Choosing Wisely®
- Released October 24, 2014
Case 1: Mrs. Lee
82-year-old woman to ED for SOB

- Mrs. Lee was started on diuretics. She appeared frail. In the ED, the physician and nurses asked for a urinary catheter (UC) for comfort.
- On the 4th day of admission, started complaining with chills, fever 102°F, and BP dropped to 90. Blood cultures and urine cultures grew Escherichia coli.
- Jane was diagnosed with urosepsis due to symptomatic CAUTI and had to be treated with intravenous antibiotics.
Choosing Wisely®
ACEP Recommendation #2

Avoid placing indwelling urinary catheters in the emergency department for either urine output monitoring in stable patients who can void, or for patient or staff convenience.

- Catheter-associated urinary tract infection (CAUTI) is the most common hospital-acquired infection.
- Clinical Study
- 2009 CDC Guidelines for Prevention of CAUTI

Catheter Associated Urinary Tract Infection (CAUTI)

- Most prevalent hospital-acquired infection: 95,483 to 387,550 annually
- Development of a CAUTI is associated with:
  - frequency of urinary catheter (UC) placement,
  - cleanliness of placement,
  - ongoing maintenance, and duration of catheterization.
- ½ of all non-obstetrical hospitalizations are admitted through the ED

Catheter Associated Urinary Tract Infection (CAUTI)

- 20-23% of admitted patients had a UC placed (30-36% for elderly)
- 91% of UCs placed within 24 hours of admission originated in the ED
- 33-50% of UCs placed in hospitalized ED patients lack documented physician orders and nearly half are inappropriate.
### 2009 CDC Prevention of CAUTI Guidelines (HICPAC)

#### A. Examples of Appropriate Indications for Indwelling Urinary Catheter Use

- **Patient has acute urinary retention or bladder outlet obstruction**
- **Need for accurate measurement of urinary output in critically ill patients**
- **Preparatory use for selected vaginal procedures**:
  - Patients undergoing urologic surgery or other surgery on contiguous structures of the genitourinary tract
  - Anticipated prolonged duration of surgery catheters inserted for this reason should be removed in PHCU
  - Patients anticipated to receive large-volume infusions or diuretics during surgery
  - Need for intraperitoneal monitoring of urinary output

- **To drain in healing of open wound or perineal or sacral wounds in incontinent patients**
- **Perioperative use in selected surgeries**
- **Required immobilization for trauma or surgery**
- **Hospice/Comfort Care/Palliative Care**

#### B. Examples of Inappropriate Uses of Indwelling Catheters

- As a substitute for nursing care of the patient or patient with incontinence
- As a means of obtaining urine for culture or other diagnostic tests when the patient can voluntarily void
- For prolonged postoperative or critical care without appropriate indications (e.g., structural repair of urologic or contiguous structures, prolonged effect of surgical anesthesia, etc.)

Note: These indications are based primarily on expert consensus.

### Appropriate Indications:

- **Accurate Measurement of Urinary Output in Critically Ill**
- **Acute Urinary Retention or Obstruction**
- **Assist Healing of Perineal and Sacral Wounds in Incontinent Patients**
- **Perioperative Use in Selected Surgeries**
- **Required Immobilization for Trauma or Surgery**
- **Hospice/Comfort Care/Palliative Care**

### Think twice before placing a catheter

- **Elderly** (especially women)
- **Immobility**
- **Incontinence**
- **Morbid obesity?**
- **Debility**
- **Use in non-critically ill cardiac and renal patients**

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Inappropriate Catheter Placement

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Case 2: Ms. James
55-year-old woman to ED for weakness

- Ms. James presents by EMS complaining of weakness. She has breast cancer with metastasis to the brain and spine a few months ago causing her to be bedridden.
- Quick assessment shows sepsis most likely from a stage 4 bed sore.
- On speaking with the husband hospice was discussed, but radiation for the metastasis is the next plan.

Choosing Wisely®
ACEP Recommendation #3

Don’t delay engaging available palliative and hospice care services in the emergency department for patients likely to benefit.

- Summary Paper
- Summary Paper
  - http://www.acep.org/uploadedFiles/ACEP/Practice_Resources/issues_by_category/administration/Palliative_Care_IP_Final_June2012_edited.pdf
- 2012 ACEP Palliative Care Information Paper
  - http://www.acep.org/uploadedFiles/ACEP/Practice_Resources/issues_by_category/administration/PalliativeCaretHeartFailure_Emerg.pdf
- Palliative Care in the ED Toolkit
  - http://www.capc.org/ipal/ipal‐ems/monographs‐and‐publications

How do people die?

1) MI or Stroke
2) Heart Failure
3) Lung Cancer
4) Dementia

Where do you want to die?

1. Home or Familiar Surroundings
2. Nursing Home
3. Hospital
4. Car Accident

Where People Die and Why They Come to the ED

100% Want to Die at Home
17% Die At Home
>70% Die In HealthCare Facility
Most Admitted Through the ED
Unmet Palliative Needs
The Conversation

Remembering that I’ll be dead soon is the most important tool I’ve ever encountered to help me make the big choices in life. Because almost everything — all external expectations, all pride, all fear of embarrassment or failure — these things just fall away in the face of death, leaving only what is truly important. Remembering that you are going to die is the best way I know to avoid the trap of thinking you have something to lose. You are already naked. There is no reason not to follow your heart.

Key Elements for Palliative Care in the ED

- Identify the patient
- Have the conversation
- Symptom management
- The Role of Hospice

Palliative Care ED Program

https://www.capc.org/ipal/pal-emergency-medicine/
Case 3: Mr. Brown
19-year-old man to ED for pain

- Mr. Brown presents with three days of lower back pain. He does not recall any trauma. It hurts worse with movement and he cannot bend over.
- Normal vital signs, no fever or other symptoms at home. Normal exam.
- No medical problems.

Choosing Wisely®
ACEP Recommendation #8
Avoid lumbar spine imaging in the emergency department for adults with non-traumatic back pain unless the patient has severe or progressive neurologic efcits or is suspected of having a serious underlying condition (such as vertebral infection, cauda equina syndrome, or cancer with bony metastasis).
Case 5: Jessica
2-year-old girl to ED for vomiting/diarrhea

- Jessica presents with two days of vomiting and diarrhea, each more than five a day. Intermittent crampy abdominal pain. Low grade fever. Siblings and parents are sick with same at home.
- Both slowing down, but decreased urine output.
- Normal vital signs, abdomen non tender. Mildly dehydrated on exam.
- No medical problems.
Choosing Wisely®
ACEP Recommendation #5

Avoid instituting intravenous (IV) fluids before doing a trial of oral rehydration therapy in complicated emergency department cases of mild to moderate dehydration of children.

- Clinical Study #1
- Clinical Review

Results

Figure 1
Patient progress through the trial.

PO, Oral hydration.
Case 5: Jessica
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Other Implementations
Pediatric Head Injury Study

- Goals:
  - Frequency of CTH in Peds
  - In compliance with PECARN/CW?
  - Peds coordinator
  - Chart review in 2014

Courtesy Dr. Ansel Soriano
Avoid unnecessary treatments in the ER

A discussion with the doctor can help you make the best decision.

It can be hard to say "No" in the emergency department. But talking with your emergency room (ER) doctor may help you avoid costly testing. That's why the American College of Emergency Physicians lists three common procedures you should know about:

- CT scans of the head for minor injury
- Urinary catheters
- Antibiotics and cultures for abscesses

CT scans of the head for minor injury. A CT scan uses X-rays to create a picture of the brain. If your head injury is not serious, a CT scan does not give useful information to the doctor. A medical history and physical exam help the doctor determine if your injury is minor. This can help you avoid a CT scan.

CT scans have risks and cost a lot. CT scans use radiation, which can increase the risk of cancer. Children, especially infants, have greater risks because their brains are still developing. Services in the ER cost a lot, because of fees for doctors, services, and facilities. A CT scan can add over $2,000 to your costs.

You may need a CT scan if you have dangerous symptoms, such as:
- An injury your doctor can see or feel.
- Becoming unconscious.
- Changes in mental state or alertness.
- Ongoing vomiting or a bad headache.

If you take a blood thinner, such as warfarin (Coumadin®), you are more likely to bleed. So you may need a CT scan, even for a minor injury.

Thank you!