**Group members & Proposed Responsibilities**

1. Stephanie Carlson: Submit assignments the day before the deadline for all assignments.
2. Emily DeDonato: Schedule meetings that all group members can attend until each assignment is finished.
3. Gina Ferris: Ensure that each deadline is met by organizing them and sending reminders at least one week in advance of each deadline
4. Suman Gupta: Record what is discussed at each meeting and send out meeting notes within a day of each meeting.
5. Elizabeth Matheson: Liaise with mentor and HSIQ administration; facilitate these tasks and inform group of information within 24 hours of correspondence.

**Mentor**: Dr. Creagh Boulger

**Specialty/Area of Focus:** Emergency Medicine and Palliative Medicine

**5 Areas of Waste and Redundancy**

Our group looked at 22 campaigns in ABIM’s Choosing Wisely Campaign and determined that three of the campaigns aligned with areas that we have recognized waste and redundancy in our own experiences. In addition to the 3 campaigns from the Choosing Wisely Campaign we also came up with two areas of waste and redundancy on our own. The 5 problems are listed below and the ones from the Choosing Wisely Campaign have the website included in the description.

**1. There is a delay in engaging available palliative and hospice care services in the emergency department for patients likely to benefit.**

* http://www.choosingwisely.org/clinician-lists/american-college-emergency-physicians-delaying-palliative-and-hospice-care-services-in-emergency-department/).

This problem is a result of the interaction of the following health system components:

* The emergency medicine team following a patient who may benefit from palliative care
* The patient himself who may be resistant to the idea of a palliative consult in the setting of an emergency department visit
* The hospital’s palliative consulting service who may not be readily available or may not make it known that their services are available.

**2. The emergency department tends to order too many CT scans of the abdomen and pelvis in young otherwise healthy emergency department (ED) patients (age <50) with known histories of kidney stones, or ureterolithiasis, presenting with symptoms consistent with uncomplicated renal colic**

* http://www.choosingwisely.org/clinician-lists/acep-ct-of-abdomen-and-pelvis-for-ed-patients-under-50/

This problem is a result of the interaction of the following health system components:

* Physicians who require additional imaging information to make the diagnosis
* The patient who wants a definitive answer
* The radiologist reading the images

**3. Too many unnecessary CT scans are ordered in the immediate evaluation of minor head injuries and clinical observation/Pediatric Emergency Care Applied Research Network (PECARN) criteria are not frequently used to determine imaging indications**

* http://www.choosingwisely.org/clinician-lists/american-academy-pediatrics-ct-scans-to-evaluate-minor-head-injuries/

This problem is a result of the interaction of the following health system components:

* Physicians who order CT scans - emergency team and inpatient provider team
* Radiologists reading unnecessary scans and not providing feedback
* Nurses caring for patients are helping to evaluate clinical status progression
* Patients desiring definitive answers and not understanding the idea of unnecessary tests

**4. Poor EMS to ED communication increases wait time for patients in need of urgent care brought in by EMS**

This problem is a result of the interaction of the following health system components:

* The EMS team not properly or efficiently communicating information to the ED
* The arrival zone staff receiving calls from the EMS team and triaging the patient coming in by EMS
* The nursing staff who will initially see the patient brought in by the EMS

**5. Literature states that efficiency in the ED can be negatively affected by resident and physician burnout. It is currently unknown the prevalence of self-perceived burnout and among EM residents at OSU.**

This problem is a result of the interaction of the following health system components:

* Hospital administration not having a system in place to determine the prevalence of burnout and the factors causing burnout
* ED resident physicians not speaking up about burnout or seeking help
* Patients being treated by EM physicians who are tired or over-worked leading to mistakes in their health management

**PRIORITIZATION MATRIX**

Our Criteria:

* Frequency of occurrence: *How often do we encounter this problem?*
* Feasibility: *How likely is it that we can perform a beneficial intervention?*
* Cost of intervention: *How affordable would an intervention to help solve this issue be?*
* Time intervention takes: *How likely is it that an intervention could be implemented in the time allotted for the HSIQ project?*
* Individuals impacted: *How many individuals are impacted by this problem daily?*
* Importance (ruled out)
* Potential benefits (ruled out)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **SG** | **EM** | **ED** | **SC** | **GF** | **Total** |
| **Frequency** | **.1** | **.3** | **.4** | **.2** | **.3** | **1.3** |
| **Feasibility** | **.3** | **.1** | **.2** | **.4** | **.1** | **1.1** |
| **Cost** | **.3** | **.3** | **.1** | **.1** | **.3** | **1.1** |
| **Time** | **.3** | **.1** | **.2** | **.2** | **.1** | **0.9** |
| **Population** | **0** | **.2** | **.1** | **.1** | **.2** | **0.6** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Frequency (1.3)** | **Feasibility (1.1)** | **Cost (1.1)** | **Low time (0.9)** | **Population (.6)** | **Total** |
| **Item 1** | **3** | **4** | **4** | **4** | **3** | **18.1** |
| **Item 2** | **2** | **1** | **5** | **2** | **2** | **12.2** |
| **Item 3** | **1** | **1** | **5** | **2** | **1** | **10.3** |
| **Item 4** | **5** | **2** | **2** | **4** | **2** | **15.7** |
| **Item 5** | **4** | **1** | **4** | **1** | **5** | **14.6** |

**Area of opportunity chosen to prioritize:** “*There is a delay in engaging available palliative and hospice care services in the emergency department for patients likely to benefit.”*

**Delayed engagement of available palliative and hospice care services in the ED for patients likely to benefit.**

Accessibility of palliative doctors

Negative culture surrounding palliative consult placement in ED

Financial resources for palliative unavailable in ED

Insufficient education on resources available

Acute focus, don’t necessarily think long-term of prognosis

Busy, noisy area not conducive to nature of palliative discussion

Limited time in ED to address palliative concern

**Team**

**Factors**

Limited palliative staff

**Organizational**

**Factors**

Consultants are not available 24/7

**Work**

**Environment**

**Individual**

**Staff**

**Patient**

**Characteristics**

Underutilized service in the ED

Understanding the scope of palliative

Prioritizing acute patients

Stigma

Incurable disease

Chronic illness

**5 Whys**

**Patient Characteristics:**

* **Chronic illness** 
  + *Why?* Environmental or genetic or combination
    - *Why?* DNA or lack of health maintenance
      * *Why?* Socioeconomic status, education, motivation
        + *Why?* Limited resources, limited understanding of disease

*Why?* Maslow’s hierarchy of needs/personal prioritization (food and survival come before making healthy choices)

* **Incurable disease** 
  + *Why?* Nature of disease
    - *Why?* No definitive treatment exists that will help the patient
      * *Why?* Limited research/medical breakthroughs and/or exhaustion of all treatment options
        + *Why?* Limited funding

*Why?* Limited awareness of the need

* **Stigma**
  + *Why?* Lack of understanding the process surrounding end of life
    - *Why?* Associated with Hospice and insurance criteria
      * *Why?* Fear of losing hope/analogous to giving up
        + *Why?* Taboo to give up on life

*Why?* Fear of death

**Individual Staff**

* **Prioritizing acute patients** 
  + *Why?* High acuity cases get treated first
    - *Why?* Goal is to save as many lives as possible
      * *Why?* The nature of the Emergency Department
        + *Why?* Doctors prioritize a patient’s life in an emergency above all else unless aware of other wishes (i.e. DNR order)

*Why?* Hippocratic oath

* **Understanding the scope of palliative**
  + *Why?* Not widely used in the ED
    - *Why?* Lack of education about palliative
      * *Why?* Lack of education regarding when it is applicable in ED
        + *Why?* EM and palliative are relatively new fields in the medical world

*Why?* Need for these services not recognized until more recently

* **Underutilized service in the ED**
  + *Why?* Thinking to place the consult
    - *Why?* Knowing when it is applicable
      * *Why?* Lack of education about scope of palliative
        + *Why?* Not included in EM training curriculum

*Why?* The need has not been widely recognized

**Work Environment**

* **Limited time in the ED to address palliative concern** 
  + *Why?* Goal is to see patients quickly
    - *Why?* EDs are usually very busy with many patients in the waiting room
      * *Why?* They are either traumas, have very urgent concerns, or couldn’t get in with their PCP
        + *Why?* PCPs don’t have openings in their schedule

*Why?* Shortage of PCPs

* **Acute focus in the ED, don’t necessarily think long-term prognosis**
  + *Why?* No scheduled follow-up
    - *Why?* Inappropriate to use ED for primary or longitudinal care
      * *Why?* Resources in ED are limited, and are primarily designated for acute care rather than chronic care
        + *Why?* Other avenues in medical system for effective chronic and/or palliative management

*Why?* Chronic conditions best managed on a long-term basis with consistent provider

* **Busy, noisy area not conducive to nature of palliative discussion**
  + *Why?* Crowded area with limited privacy
    - *Why?* Trying to maximize space to manage acute care
      * *Why?* ED wait times are a major complaint nationwide
        + *Why?* Many people have acute issues

*Why?* Not enough patients have an established PCP

**Organizational Factors\***

* **Consultants are not completely available 24/7**
  + *Why?* Palliative care physicians are not present in the hospital on weekends and evenings
    - *Why?* There are not enough palliative patients to make this cost effective
      * *Why?* The consult service is under-utilized
        + *Why?* Many physicians do not know the purpose of Palliative medicine

*Why?* Palliative medicine is not adequately taught in all US medical schools

* **There is not sufficient education on the resources available**
  + *Why?* This is an emerging field
    - *Why?* This need for palliative is newly being recognized in emergency departments
      * *Why?* The emergency department traditionally focuses on acute needs
        + *Why?* There is not enough time and resources for the emergency team to address the chronic illness underlying the acute presentation

*Why?* The patient volume is too high for ED physicians to spend time on this more chronic issue

* **Financial resources are not available for palliative medicine in the ED** 
  + *Why?* Financial resources in the ED are allocated towards other life threatening, acute issues (eg. EMS, trauma, resuscitation, etc)
    - *Why?* The ED traditionally focuses on acute care and stabilization
      * *Why?* There are inpatient services with the appropriate financial resources to care for chronic and terminal illnesses
        + *Why?* The inpatient services need these resources to care for patients over a longer period of time and monitor how a long-term illness progresses

*Why?* Patients spend a longer period of time recovering/being treated on an inpatient service than in the ED

**Team Factors**

* **There is a negative culture surrounding placing a palliative consult in the Emergency Department**
  + *Why?* Emergency physicians don’t want to “give up” on patients
    - *Why?* It is difficult to change focus from saving lives to comfort care
      * *Why?* Comfort care is not explicitly taught in most medical schools and residency programs
        + *Why?* There are not enough palliative physicians to teach this topic and advocate for its presence in curriculums

*Why?* The few palliative physicians focus their time solely on patient care

* **Accessibility of palliative doctors**
  + *Why?* Limited interaction between teams
    - *Why?* Limited awareness of scope of palliative services
      * *Why?* Palliative is not often physically present in the ED
        + *Why?* There is not a good place for palliative to work in the emergency department

*Why?* There is limited space for consultants

* **Limited palliative staff**
  + *Why?* Lack of personnel
    - *Why?* Lack of funding
      * *Why?* Newly recognized field
        + *Why?* Utility of palliative consult service recently recognized

*Why?* Media more recently bringing these concerns to the public

**Final effect:** Delayed engagement of available palliative and hospice care services in the emergency department for patients likely to benefit.