**Choosing Wisely Knowledge and Education Group (KEG) Meeting – October 16, 2019**

**Attendees:**

Cortes, Jennifer

Reddy, Anita  
Zimmerman, Jerry

Vachharajani, Vidula

Collins, Reagan

Bauer, Seth

Brown, Anne Rain

Rech, Megan

Carter, Chris

Yeung, Amy

Berger, Karen

Bolesta, Scott

Torbic, Heather

Roberts, Russ

Jagpal, Sugeet

Hynes, Ally

**Minutes:**

* *Results of Steering Committee election and next steps* – Congrats to all!
  1. Maya Dewan – Communications/Public Relations Chair
  2. Sugeet Jagpal – Secretary
     1. Assistant Professor of Pulmonary/CC Physician- Rutgers University
     2. Quality-M&M Committee Chair
  3. Laboratory Sub-committee Chair – Ally Hynes
     1. ED Physician and 1st year Surgical Critical Care fellowship
  4. Medication Sub-committee Chair – Anne Rain Brown
     1. Critical care clinical pharmacist- MICU, SICU, triage pharmacist- MD Anderson
  5. Radiology Sub-committee Chair – Matthew Tyler
  6. Next steps – steering committee will draft mission and goals to be discussed at November meeting
     1. There was expression of uncertainty of KEG purpose from the survey. Hoping to provide more clarity with the development of mission and goals for meeting in November.
* *Starting Choosing Wisely and Less is More initiatives locally – A conversation with Jerry Zimmerman, MD, PhD*
  1. Idea of promoting value is important. Last week JAMA article on waste in medicine reported that waste constitutes 25% of all healthcare costs. In addition, there was 6 – 8 editorials, of which 1 reported that the amount of waste in healthcare annually is more than all of the worth of the Medicare-Medicaid system. We have an opportunity to decrease waste in ICU where we spend a lot of money and Choosing Wisely is a good place to start.
  2. There are 5 elements of quality improvement but need to establish culture change and how people think about their work. Seattle’s children-QI is a big deal and institution uses Toyota’s LEAN methodology approach.
     1. As an ICU with the 5 elements they were all over the board. Some up to speed and others weren’t.
        1. Avoid scheduled laboratory testing: Started by looking at duplicate testing; BUN, Cr, LFT’s. Identified a lot of duplication. Primary place was transition from ER to ICU. People weren’t looking at labs ordered in ED. Interventions implemented in unit: 1. POC testing available in unit…outside of code they eliminated the use of POC testing 2. Reminder to specific people ordering the same test more than once in a day; some faculty not ready that part. Haven’t mastered but so far they have made a dent in waste.
        2. PRBC transfusion: Established that essentially a hematocrit goal of 20% is ok for everyone.
        3. Parenteral nutrition- Article that enteral nutrition early is beneficial. As an ICU, they didn’t really use parenteral nutrition within the 1st 7 days so not a big issue for their ICU.
        4. Sedation- 1st PICU in country to develop “comfort protocol” addressed sedatives and analgesics. Point was to wean sedation based on specific criteria instead of stopping sedation in the am or decreasing by 50%. They were able to reduce sedation and analgesic medications and basically eliminated use benzodiazepines. Didn’t do a good job sustaining this practice so sedation protocol fell apart and they lost all of the gain they had made. Currently, re-emphasizing the need for weaning sedation; not at a plateau or back to where they were before. Learned a good lesson with early success and late failure because they didn’t have a good plan for sustainability.
        5. Comfort care: Rich resources around palliative care. Most patients at risk for death or severe disability consult palliative care.
        6. General: Embraced all of the elements but not completely and not always with a sustained effort. All these beg the questions, do you really have a clinical standard for each? Protocol or pathway should be developed that includes evidence based practices with a consensus from a wide stakeholder group. Owned by an individual and transitioned to new owner if needed. Need measurable variables or outcomes so you can show data to staff in improvement. Protocol can prevent a lot of the individualized noise in patient management.
     2. Anita Reddy-who have you approached nay sayers or culture of negativity in your practice?
        1. The thoughts that each practitioners believes the way they conduct their work is the best is archaic. Can’t measure improvement this way. Include these individuals in protocol development. Remember that it is not static and will be continuously changing based on evidence with the goal of improving patient care. The naysayers need to be on top of list as the stakeholder.
     3. I like the idea of measurable effects? How do you measure adherence of protocol? How is it successful vs. not successful?
        1. What are the compliance variables going to be? Transfusion-easy-pick a hemoglobin. Create a run chart over time and adjusting the CI over time.
        2. TPN ordered during first week-how often is that happening?
        3. Sedation- have a more complex metric. If RASS score > -1 then it’s a ding because patient should be weaned. Proportion of patients RASS score -2 or >. RASS -1 x 2 and sedation not weaned. No bolus doses given for sedation over last 12 hours and drip hasn’t been weaned. Whichever variable is chose, ensure to try and work with EMR people so that data can be easily extracted.
     4. Anita Reddy-Has Seattle Childrens been able to broaden efforts out of PICU into the entire hospital? If so, how was that lead or driven?
        1. For the Choosing Wisely initiatives, we have not made effort to move out of the ICU into general hospital ward. Still have a lot of fish to fry in the ICU. Other examples of clinical standard work outside of the ICU is the DKA pathway. Begins in ED and extends to the ICU and then to wards. That process is an example that was derived by all types of stakeholders. Group meets every month for last 5 or 6 years. Part of salary is derived from QI involvement.
     5. Speak to implementing in different hospitals? Worked in community hospital and it was easier there but academic medical center have had more of a struggle?
        1. Issue is that in academic medical center a lot of stakeholders that can have their ego tarnished. Community, a smaller group of individual that work much closer together. Academia much greater number of individuals working together. Best way to overcome is to bring a group together of multiple stakeholders.
     6. Jen Cortes- Did you have barriers in regards to nursing buy in? If so, how did you overcome these?
        1. When started-engaged nurses. Asked the questions, do we want to turn off sedation every morning? Nurses freightened by the idea of cold turkey stop with sedation. They agreed to continuous weaning and at times they were thrilled to be empowered by the idea of escalating or weaning of sedation. Nurses are able to do this without getting an order. Nursing staff was more experienced back then and now much younger staff and see less confidence. Currently, at a point where they need to be asking this question again. Should we turn off all sedation and provide all essential staff and resources at bedside? Also, starting to use clonidine and methadone as adjunct therapy to help with wean.
* *Survey results and discussion* – Themes:
  1. What do you want to see the KEG do? 64% education, 86% collaboration, 86% research
  2. Comments: Educational pamphlet, collaboration and implementation of ideas, database for tracking, decision support, outcomes based research
  3. Our steering committee will look at it in a bit more detail. There is a 1 page handout on choosing wisely handout of critical care on website.
* *December meeting cancellation* – due to holidays/vacations
* *February meeting cancellation* – due to SCCM, we will meet at SCCM – tentatively Monday, February 17 from 2:30-3:30, confirmation pending
* *Update on conference call options*:
  1. No availability of Zoom for KEGs – free trial only allows 40 minute meetings
  2. Steering committee will trial in few weeks*.* If anyone has ideas please pass them on and we will look into them.
* *November meeting*
  1. Review of mission and goals initial draft
  2. Guest speaker – Gary Procop, MD; Cleveland Clinic, Lab Stewardship
     1. If you have any suggestions for other speakers please pass it on and we can reach out so they can share their experiences.
* Questions/Comments
  1. Like the format-
     1. Russ Roberts- It would be helpful to know what barriers others have experienced in their efforts. Hearing some of that experience helps junior people trying to get involved. Anita- at Cleveland clinic they have implemented lab stewardship- lifetime alerts, duplicate testing, expensive testing. Barriers seen: 1. Getting stakeholders to the table. Not all can attend or have an interest. Then once something is implemented, others will come out of wood works and provide feedback after it’s been developed and implementing. 2. Personally, spends a lot of time creating agendas, minutes, etc. She doesn’t have all the resources and asking for them is challenging especially now that medicine is cutting costs. 3. Continue implemented efforts moving forward by hardwiring things. Protocols, guidelines, hardwire to EMR, SMART alerts into the system, etc.
     2. Sugeet- charge is to use Choosing Wisely. Great jumping off point for looking at ICU improvement. Need to be conscious that all hospitals are different and have made goals for their fiscal year. Wondering if different hospitals may have different ways to partner. Task of KEG, how to capitalize on momentum of things that already exist. Also, larger number of stakeholders in academic ICU. Suggest separating home base people from rotating individuals.
     3. Jerry Zimmerman- group needs to be aware that if as a group we want to take on an activity with SCCM membership then need to undertake a strategic proposal. Ideas would be beneficial to the membership.
        1. Anita Reddy- if we wanted to send a survey to the membership we would need to put in a proposal?
        2. Jerry Zimmerman- That may not need a proposal but would need to go to research committee group that looks at surveys. Rules around constructing a survey so that everyone is involved and disciplines are not left out. Can send a letter to the president directly. Include the idea for the survey, and ask can we move forward or does this need to be part of a strategic proposal? Outcomes research or database would be examples of what needs to be made into strategic proposal.
     4. Sugeet- We could speak to institute of healthcare improvement and how to change ICU. Disseminating best practices does that have to go through a committee?
        1. Jerry Zimmerman- Good idea to just be transparent about what is going on. KEG are new and people are seeing where these are headed. Different than committees; have charges, very well defined and have SCCM resources to do their jobs. Currently, KEGs have none of that. Overtime, Evolution of KEG’s may evolve into committees. Need to let council know what you are doing especially if want SCCM support. Pamphlet is a good idea if it is made to be useful for practitioners and maybe even families. Project could be to distribute this in many avenues. As move forward, stay in touch with council and let them know if group is very active more than once a year.