

Initial Report





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1. Clinical decision rules (CDRs) are decision support tools that synthesize evidence for use in bedside practice. The Ottawa Ankle Rules or the Nexus Criteria are examples of such tools. In your clinical practice, do you use CDRs?

#	Answer	Bar	Response	%
1	Yes		57	100%
2	No		0	0%
	Total		57	



Statistic	Value
Min Value	1
Max Value	1
Mean	1.00
Variance	0.00
Standard Deviation	0.00
Total Responses	57

2. Think about a month of clinical shifts. How often would you say you use a CDR in a month?

#	Answer	Bar	Response	%
1	< 1 per Month		0	0%
2	Once a Month		0	0%
3	2-3 Times a Month		6	11%
4	Once a Week		10	18%
5	2-3 Times a Week		24	42%
6	Daily		17	30%
	Total		57	

Statistic	Value
Min Value	3
Max Value	6
Mean	4.91
Variance	0.90
Standard Deviation	0.95
Total Responses	57

3. Think of when you care for a patient in whom pulmonary embolus (PE) is on the differential. Do you use a CDR when evaluating patients with suspected PE?

#	Answer	Bar	Response	%
1	Yes		52	91%
2	No		5	9%
	Total		57	

Statistic	Value
Min Value	1
Max Value	2
Mean	1.09
Variance	0.08
Standard Deviation	0.29
Total Responses	57

4. Think of when you are evaluating somebody for PE. Which of the following criteria do you use? (Click all that apply)

#	Answer	Bar	Response	%
1	The Wells Criteria (a.k.a Canadian or Modified Wells or Wells Score)		47	82%
2	The Geneva or Modified Geneva Score		3	5%
3	The Charlotte Rule		1	2%
4	Clinical Judgment (By this we mean you use only clinical judgment and no other criteria)		19	33%
5	Other		14	25%

Other
Perc
PERC
PERC rule
PERC rule
PERC
perc
PERC
PERA
perc
PERC
PERC
PERC
PERC
Perc





Statistic	Value
Min Value	1
Max Value	5
Total Responses	57

5. Think of the ED in which you work the majority of your shifts. Does this hospital have the ability to perform D-dimer testing?

#	Answer	Bar	Response	%
1	Yes		57	100%
2	No		0	0%
	Total		57	




Statistic	Value
Min Value	1
Max Value	1
Mean	1.00
Variance	0.00
Standard Deviation	0.00
Total Responses	57

6. What type of D-dimer assay does that hospital's laboratory use?

#	Answer	Bar	Response	%
1	ELISA (quantitative)		7	13%
2	Latex agglutination (quantitative)		6	11%
3	Latex agglutination (qualitative)		0	0%
4	Immunoturbidimetric (quantitative)		1	2%
5	RBC agglutination/"SimpliRED" (qualitative)		0	0%
6	Immunochromatography/"Simplify" (qualitative)		0	0%
7	I do not know what type of assay they use		42	75%
	Total		56	





Statistic	Value
Min Value	1
Max Value	7
Mean	5.66
Variance	5.65
Standard Deviation	2.38
Total Responses	56

7. Is D-dimer ordering ever done as part of a triage or nursing protocol? In other words, can a triage nurse or nurse caring for the patient order a D-dimer without first consulting a physician? (For the purposes of this question assume nurse practitioners or physician assistants are distinct from nurses)

#	Answer	Bar	Response	%
1	Yes		10	18%
2	No		31	54%
3	I don't know if nurses can order D-dimer tests		16	28%
	Total		57	

Statistic	Value
Min Value	1
Max Value	3
Mean	2.11
Variance	0.45
Standard Deviation	0.67
Total Responses	57

8. For which patients do you order a D-dimer during the evaluation for PE?(click all that apply)

#	Answer	Bar	Response	%
1	Low risk patients		51	89%
2	Intermediate risk patients		12	21%
3	High risk patients		1	2%
4	I don't order D-dimers		2	4%

Statistic	Value
Min Value	1
Max Value	4
Total Responses	57

9. Are you familiar with the Pulmonary Embolism Rule Out Criteria (PERC) Rule?

#	Answer	Bar	Response	%
1	Yes		51	89%
2	No		6	11%
	Total		57	

Statistic	Value
Min Value	1
Max Value	2
Mean	1.11
Variance	0.10
Standard Deviation	0.31
Total Responses	57

10. How often do you use or consider using the PERC rule when evaluating for PE?

#	Answer	Bar	Response	%
1	Never		1	2%
2	Rarely		4	8%
3	Sometimes		21	43%
4	Quite Often		13	27%
5	Very Often		10	20%
	Total		49	




Statistic	Value
Min Value	1
Max Value	5
Mean	3.55
Variance	0.96
Standard Deviation	0.98
Total Responses	49

11. Do you feel the PERC rule has been sufficiently validated? That is to say, do you feel there is a sufficient evidence to merit its use to determine which low risk patients do NOT need further testing (including D-dimer) to exclude PE?

#	Answer	Bar	Response	%
1	Yes		35	70%
2	I'm not familiar enough with the PERC rule to answer this question		14	28%
3	No		1	2%
Total			50	




Statistic	Value
Min Value	1
Max Value	3
Mean	1.32
Variance	0.26
Standard Deviation	0.51
Total Responses	50

12. Do you require Radiology Department approval for ordering a PE protocol CT at your facility? By approval we mean Radiology may refuse to perform a PE protocol CT if they feel it is not clinically indicated?

#	Answer	Bar	Response	%
1	Yes		3	5%
2	Maybe (May depend on which Radiologist is working)		22	39%
3	No		31	55%
	Total		56	

Statistic	Value
Min Value	1
Max Value	3
Mean	2.50
Variance	0.36
Standard Deviation	0.60
Total Responses	56

13. Do you believe that Emergency Physicians over-order PE protocol CT exams?
 By over-order, we mean that they are ordered on patients who can be reliably ruled out via other means (ie. can be ruled out by PERC or negative d-dimer) or when V/Q scanning or Ultrasound are available (and patient is appropriate for testing by those means).

#	Answer	Bar	Response	%
1	Yes		29	52%
2	Maybe		19	34%
3	No		8	14%
	Total		56	

Statistic	Value
Min Value	1
Max Value	3
Mean	1.63
Variance	0.53
Standard Deviation	0.73
Total Responses	56

14. In your opinion, what forces might oppose a program to reduce over ordering of PE protocol CT exams at your institution? (Please select all that apply)

#	Answer	Bar	Response	%
1	Diagnostic algorithms (which may include D-dimer, ultrasound imaging, or V/Q scanning) won't be as accurate as CT imaging		14	30%
2	Diagnostic algorithms (which may include D-dimer, ultrasound imaging, or V/Q scanning) won't be as timely as CT imaging		19	41%
3	Lack of patient acceptance		7	15%
4	Lack of administrative support		3	7%
5	Concern over perceived medico-legal implications		39	85%
6	Lack of nursing acceptance		2	4%
7	Lack of additional diagnostic resources (e.g. ultrasound, V/Q, D-dimer)		26	57%
8	Other		5	11%

Other
standard of care
Physician unable to adopt new approach different than what they have always done.
Lack of physician acceptance
Time in ED for work-up
Sometimes it is the fastest, easiest way to R/O PE

Statistic	Value
Min Value	1
Max Value	8
Total Responses	46

15. In your opinion, what forces might favor a program to reduce over ordering of PE protocol CT exams at your institution?(Please select all that apply)

#	Answer	Bar	Response	%
1	Support from administration		22	47%
2	Support from nursing		8	17%
3	Support from local/regional regulatory mandates		17	36%
4	Published guidelines and policy statements		39	83%
5	Availability of additional diagnostic resources		31	66%
6	Medico-legal support (ie. risk management support, tort reform)		32	68%
7	Other		0	0%

Other

Statistic	Value
Min Value	1
Max Value	6
Total Responses	47

16. If you have experience with developing and implementing a protocol to help limit unnecessary PE protocol CT use in your facility what are the most important lessons you have learned?

Text Response	
you need to perform continual evaluation regarding compliance by the providers and provide them regular feedback	
n/a	
Na	

Statistic	Value
Total Responses	3

17. Do you believe that you personally over order PE protocol CT exams?

#	Answer	Bar	Response	%
1	Yes		13	23%
2	Maybe		25	45%
3	No		18	32%
	Total		56	

Statistic	Value
Min Value	1
Max Value	3
Mean	2.09
Variance	0.56
Standard Deviation	0.75
Total Responses	56

18. Would you support an algorithm-based approach to ordering PE protocol CT examinations. By algorithm based approach we mean calculating a pre-test risk of PE (e.g. low, intermediate, high) followed by possible additional screening evaluation for PE (PERC or D-dimer) followed by further testing (e.g. CT, V/Q, Ultrasound) if indicated?

#	Answer	Bar	Response	%
1	Yes		55	98%
2	No		1	2%
	Total		56	

Statistic	Value
Min Value	1
Max Value	2
Mean	1.02
Variance	0.02
Standard Deviation	0.13
Total Responses	56

19. List any specific issues you would like covered at the "Reducing CT Use for PE" Journal Club

Text Response	
d-dimer threshold likely needs revising in normal and pregnant individuals	
Review cdrs	
The only thing that will ever impact radiographic testing is lawyer reform. Period. Defensive medicine, not science, is the issue.	
risks of anticoagulation of young people	
availability of V?Q scan and US during non-working hours.	
how to increase general acceptance of algorithm	
Sometimes clinical suspicion is not in sync with protocols, and when they conflict, the former should rule.	
Statistic	Value
Total Responses	7

20. Where do you work clinically the majority of the time? By "majority of the time" we mean over 50% of your shifts occur at this site. (You may pick up to 2 sites)

#	Answer	Bar	Response	%
1	Alton Memorial		0	0%
2	Anderson		1	2%
3	Barnes Jewish		48	86%
4	Barnes Jewish St. Peter's		2	4%
5	Barnes Jewish West County		0	0%
6	Christian Northeast		0	0%
7	Depaul		1	2%
8	Des Peres		0	0%
9	Missouri Baptist (MoBap)		0	0%
10	St. Anthony's		0	0%
11	St. Clare		1	2%
12	St. John's Mercy		1	2%
13	St. Joseph West		0	0%
14	St. Louis University		0	0%
15	St. Luke's		1	2%
16	Other		1	2%
	Total		56	

Other
St Joseph

Statistic	Value
Min Value	2
Max Value	16
Mean	3.84
Variance	7.96
Standard Deviation	2.82
Total Responses	56

21. How many years have you practiced Emergency Medicine since you finished your residency?

#	Answer	Bar	Response	%
1	Currently in training		28	51%
2	1-5 years		11	20%
3	6-10 years		6	11%
4	11-15 years		2	4%
5	16-20 years		4	7%
6	Over 20 years		4	7%
	Total		55	

Statistic	Value
Min Value	1
Max Value	6
Mean	2.18
Variance	2.60
Standard Deviation	1.61
Total Responses	55