A Survey of the Use of Noninvasive Ventilation in Academic Emergency Departments in the United States

Dean R Hess PhD RRT, Jessica M Pang, and Carlos A Camargo Jr MD DrPH

OBJECTIVE: To determine the frequency of, and barriers to, use of noninvasive ventilation (NIV) for adult patients with acute asthma, chronic obstructive pulmonary disease (COPD), and congestive heart failure (CHF) in academic emergency departments (EDs). METHODS: A survey instrument was developed by the authors, pilot tested, and distributed to one physician (MD) and one respiratory therapist (RT) at the 132 hospitals with emergency medicine residencies. RESULTS: The response rate was 90%. Ninety-nine percent of RTs and 64% of MDs are very familiar with NIV (P < .001). The reported time needed to initiate NIV was < 10 min for 41% of sites (< 20 min for 89%). Compared to the time requirement in other clinical areas, 60% of RTs reported that NIV “takes no additional time” in the ED. An RT is always present in 38% the EDs, and equipment for NIV is readily available in 76% of the EDs. The majority reported that NIV use is about right for acute COPD, CHF, and asthma. NIV is used infrequently for asthma (89% reported use in < 20% of patients), while 66% reported use in > 20% of COPD patients and 67% reported use in > 20% of CHF patients (P < .001, as compared to asthma). The perceived utility of NIV was significantly different between the 3 diagnoses (P < .001); there was more uncertainty about the utility of NIV for asthma. Bilevel ventilators and oronasal masks are most commonly used for NIV. Nearly all of the centers administer bronchodilators in-line with NIV. CONCLUSIONS: Consistent with available evidence, NIV use is more common in the ED for acute COPD and CHF than for acute asthma. Barriers to greater use of NIV in the ED include physician familiarity, availability of RT and equipment in the ED, and time required for NIV. For acute asthma, uncertainty about therapeutic benefits remains a challenge. Key words: asthma, chronic obstructive pulmonary disease, congestive heart failure, emergency medicine, noninvasive ventilation, respiratory care, survey. [Respir Care 2009;54(10):1306–1312. © 2009 Daedalus Enterprises]

Introduction

Use of noninvasive ventilation (NIV) is standard practice for patients presenting with severe exacerbation of chronic obstructive pulmonary disease (COPD) and acute congestive heart failure (CHF), where it has been shown to decrease intubation rate and improve survival. The benefit of NIV in other conditions such as severe acute asthma is unclear, primarily because it has not been adequately studied. Because many patients with acute respiratory failure present first to the emergency department (ED), it seems reasonable that this should be a setting where NIV is commonly used. The participants in an international consensus
conference recommended that NIV can be initiated in the ED. The practice guideline by Sinuff et al included the ED as a site for use of NIV. However, the extent and appropriateness of NIV use in academic EDs is unknown. Surveys of the use of NIV have been conducted, but only two have been specific to the ED setting, and none has been specific to academic EDs in the United States. We conducted this study to determine the frequency of, and barriers to, NIV use in academic EDs in the United States.

Methods

Questionnaire Development and Pilot Testing

This study was conducted by the Emergency Medicine Network (EMNet, http://www.emnet-usa.org). The survey instrument was developed by two of the authors (DRH and CAC), who have considerable academic and clinical experience in the use of NIV and survey research involving the ED. Content validity was augmented by pilot tests including emergency physicians (4 members of the EMNet Steering Committee) and 14 respiratory therapists (RTs). These individuals were chosen because they practice in an academic hospital and they have expertise related to the subject matter of the survey. These individuals were asked to comment on the following aspects of the survey:

1. Time. How many minutes were required for you to complete the survey?
2. Clarity. Are any questions ambiguous? If so, which ones? Suggestions to make those questions more clear?
3. Face validity. Are there any questions that are unimportant and can be deleted?
4. Content validity. Any additional questions that absolutely must be included, remembering that this will lengthen the survey and take more time to complete?
5. Utility. Do you think respiratory directors will be willing to complete this survey?

Dr Hess as editor in chief was blinded to the identity of the peer reviewers of this paper.

Correspondence: Dean R Hess PhD RRT FAARC, Respiratory Care, Ellison 401, Massachusetts General Hospital, 55 Fruit Street, Boston MA 02114. E-mail: dhess@partners.org.
The survey questionnaire was revised according to the feedback we received. The survey instrument is available from the authors upon request. The study protocol was approved by the institutional review board of the Massachusetts General Hospital.

**Data Collection**

The survey population was the 132 general EDs in the United States with accredited emergency medicine residency training programs in calendar year 2007. The physician director of the emergency residency program and the director of respiratory care were identified at each site and invited to complete the survey. These individuals were asked to complete the questionnaire themselves or to solicit input from others at the site. The survey questionnaire was Internet-based and self-administered, although a hard copy of the survey was made available to those who requested it. To improve the response rate, e-mail and telephone follow-up was conducted for non-respondents.

**Data Analysis**

Data were aggregated according to response categories. Percentages were calculated and differences between groups were determined via chi-square analysis. Two-tailed $P \leq .05$ was considered statistically significant.

**Results**

**Response Rate**

We received a response from 119 of the 132 hospitals with an emergency medicine residency program (90%). A map of the participating and nonparticipating sites is provided as Figure 1.

**Familiarity and Time Requirement**

Sixty-four percent of physicians (MDs) and 99% of RTs reported that they are very familiar with NIV ($P < .001$). Compared to the time requirement in other clinical areas, 60% of RTs reported that NIV “takes no additional time” in the ED; 11% reported that it “usually” or “always” takes a lot of time; the remainder reported that NIV takes “a little more time.” The RTs reported that NIV is used $\geq 1$wk in 92% of EDs, 98% of intensive care units (ICUs), 89% of step-down units, and 70% of general care units ($P < .001$). RTs reported that use of NIV in the ED is similar to use elsewhere in the hospital ($P = .30$, Fig. 2).

**Respiratory Therapist and Equipment Availability**

An RT is primarily responsible for initiation of NIV in 96% of the EDs. In 38% of the hospitals an RT is always available in the ED. Equipment for NIV is stored in the ED in 76% of the reporting hospitals. NIV is initiated in $< 10$ min in 41% of the hospitals, and in $< 20$ min in 89% of the hospitals.

**Use by Diagnosis and Perception of Utility**

The reported use of NIV for asthma was less than that for COPD and CHF (Fig. 3). NIV use in $\geq 20$% of cases was reported by 14% of respondents for asthma, 66% of respondents for COPD, and 67% of respondents for CHF ($P < .001$). NIV use in $< 10$% of cases was reported by 70% of respondents for asthma, 17% of respondents for COPD, and 19% of respondents for CHF. The majority of respondents reported the perception that the use of NIV is about right for each of the diagnoses ($P = .16$, Fig. 4). About a third of physicians and RTs reported that NIV does not help, or they are uncertain of its utility, for acute asthma (Fig. 5). The majority of MDs and RTs reported the perception that NIV often helps for acute COPD or acute CHF. The perceptions of the utility of NIV were significantly different between the diagnoses of asthma, COPD, and CHF ($P < .001$).

**Equipment Used for Noninvasive Ventilation**

In 51% of the centers only bi-level ventilators are used for NIV; 82% of the centers reported that they use bi-level ventilators in $\geq 50$% of cases. A ventilator with an oxygen...
blender is used by 71%, and 41% reported using a fraction of inspired oxygen (FiO₂) ≤ 0.6 for NIV. In 17% of the centers only oronasal masks are used for NIV; 76% reported use of oronasal masks in ≥ 50% of cases. In addition, 15% never use oronasal masks, 28% never use nasal masks, and 72% never use total face masks. Nearly all (90%) of centers administer bronchodilators in-line with NIV; 86% use nebulizers, and 14% use pressurized metered-dose inhalers. Most (85%) of the centers reported that this therapy is effective, and 88% reported that this therapy is technically easy.

Discussion

The major findings of this national survey are: (1) NIV use is more common in the ED for COPD and CHF exacerbations than for acute asthma, (2) NIV use could be higher for COPD and CHF, (3) barriers to greater NIV use in the ED include physician familiarity and availability of an RT and equipment in the ED, and (4) there is uncertainty about the therapeutic benefits of NIV for acute asthma.

A robust evidence base supports the use of NIV for acute COPD or CHF. Picot et al1 conducted a systematic review of 14 randomized controlled trials (RCTs) reporting the use of NIV for acute COPD. There was an approximately 60% reduction in the risk of intubation in the NIV group, when compared to usual medical care, with a number-needed-to-treat of 4 (95% confidence interval 4–5). There was also nearly a 50% reduction in mortality, with a number-needed-to-treat of 10 (95% confidence interval 7–20).

Vital et al2 conducted a systematic review of 9 RCTs comparing CPAP to usual patient care; 5 RCTs that compared NIV to usual standard care; 3 RCTs that compared CPAP, NIV, and usual medical care; and 4 RCTs comparing CPAP plus usual medical care to NIV plus usual medical care. With CPAP, a constant pressure greater than atmospheric is applied to the mask throughout the respiratory cycle. With NIV, the pressure in the mask increases during the inspiratory phase (for example, pressure-support ventilation). In other words, inspiratory assistance is provided with NIV, but not for CPAP. When studies of CPAP and NIV are combined, there was a significantly lower endotracheal intubation rate for patients treated with CPAP or NIV, compared with standard medical care alone, with a number-needed-to-treat of 8. There was also a significant reduction in hospital mortality for patients treated with CPAP or NIV, compared with standard medical care alone, with a number-needed-to-treat of 14. However, there was no significant difference between NIV and CPAP for
the outcomes of endotracheal intubation or mortality. In our survey we asked only about NIV; we did not include separate questions about NIV and CPAP.

In contrast to the strong evidence supporting the use of NIV for acute COPD and CHF, evidence is lacking for the use of NIV for acute asthma. For example, a Cochrane review by Rowe et al\(^1\) concluded that, despite some interesting and very promising preliminary results, the use of NIV for acute asthma remains controversial. The results of our survey are consistent with this evidence. NIV was used more commonly for acute COPD and CHF than for acute asthma, and the survey participants were uncertain of the therapeutic benefits of NIV for acute asthma.

Although consensus groups have recommended NIV as first-line standard therapy for patients with acute COPD and CHF,\(^5,13\) the appropriate utilization rate in these patients is not clearly established. Several reports from France suggested that the utilization rate should be high. Girou et al,\(^14\) in an 8-year retrospective evaluation of NIV in a single center, reported an increased NIV utilization over the study period that was associated with a decrease in mortality and nosocomial infections. In the final year of that study (2001), ICU-use of NIV was 78% of patients with acute COPD and 22% of patients with acute CHF. In a survey of NIV use in 70 French ICUs, Demoule et al\(^10\) reported that first-line NIV use in patients not intubated before ICU admission was 64% in patients with acute-on-chronic respiratory failure (most with COPD) and 40% in patients with acute CHF.

In our survey NIV use in ≥ 20% of cases was reported by 66% of respondents for COPD, and by 67% of respondents for CPE. Put another way, NIV is used in < 20% of cases of acute COPD and CHF in about a third of the EDs in our survey. It is interesting to note that NIV was used in < 10% of cases by 17% of respondents for COPD and 19% of respondents for CHF. This suggests that the utilization of NIV in academic EDs in the United States could be increased for patients presenting with acute COPD or CHF. Although we did not ask about the frequency of contraindications for use of NIV in the ED, it is unlikely that usual criteria for initiation of NIV would prevent its use in more than 90% of patients in nearly 20% of EDs.

In our survey bi-level ventilators were most commonly used for NIV. This differs from the survey by Demoule et al,\(^10\) in which an ICU ventilator was used in 79% of cases and a bi-level ventilator was used in 12% of cases. It would thus appear that bi-level ventilators may be used more commonly in the United States than in France. In the survey by Vanpee et al in Belgium,\(^12\) bi-level ventilators were used for the majority of NIV cases. It is interesting to note that, increasingly, ICU ventilators are designed with both invasive and noninvasive ventilation modes.\(^15,16\) We also found that oronasal masks are most commonly used for NIV. This is similar to the surveys of Demoule et al\(^10\) and Vanpee et al\(^12\) and it is consistent with available evidence suggesting better patient tolerance of an oronasal mask in patients with acute respiratory failure.\(^17,18\) In our survey, aerosolized bronchodilators were commonly administered with NIV, consistent with the literature reporting effectiveness of this therapy.\(^19\)

There have been 6 other surveys of NIV use published (Table 1)\(^7-12\) and 2 of these focused on use in the ED.\(^7,12\) Our study is unique in that, to our knowledge, ours is the only survey of NIV use that focused on academic EDs in the United States and ours is the only one to survey RTs as well as MDs. Vanpee et al\(^12\) surveyed head physicians in Belgium. Unlike our study, only 13% of the EDs in this study were in academic hospitals (the remainder were community hospitals). Unlike in the United States, the responsibility for initiation of NIV in Belgium is assumed by a physician and nurse working together. At the time of this survey (2001), NIV was used in 49% of the EDs in Belgium, which is less than the reported use in our survey. Reasons given for not using NIV in the Vanpee et al\(^12\) study were no available equipment in 71%, lack of experience with NIV in 33%, and more time-consuming for physicians and nursing staff in 23%. This is consistent with our survey results, in which only 64% of MDs reported that they are very familiar with NIV, only 76% of sites reported that equipment for NIV is stored in the ED, and only 60% of RTs reported that NIV takes no additional time in the ED. The initiation of NIV may be more time-consuming in the first hour of therapy, and this should be appreciated by those responsible for providing this therapy.\(^20\) Browning et al,\(^7\) in a survey of NIV use in EDs in the United Kingdom in 2006, reported that although NIV is commonly used in EDs in the United Kingdom, practices vary significantly. They suggested the development of guidelines on when and how to use NIV in ED practice. In a survey by Burns et al\(^8\) of NIV use in Ontario, 80% of responding sites had guidelines, protocols, or policies related to the initiation of NIV. There have been several reports of the development and implementation of NIV guidelines.\(^6,21\)

The results of our survey suggest that important barriers to greater use of NIV in the ED include physician unfamiliarity, availability of an RT and equipment in the ED, and the time delay in initiation of NIV. Our results are consistent with other surveys. Of example, in the survey by Maheshwari et al\(^11\) the top 2 reasons given for lower NIV utilization rates were a lack of physician knowledge and inadequate equipment. In the survey by Burns et al\(^8\) ED physicians utilized NIV less frequently than physicians specialized in critical care and respirology; they also reported that a greater number of noninvasive ventilators were associated with greater use.
We suggest that several strategies might be used to increase NIV utilization in the ED. A knowledgeable and enthusiastic clinical champion is important when initiating an NIV program. Ideally the use of NIV should be multidisciplinary and include RT, MD, and nurse champions. Knowledge and training are also important. Knowledge of the evidence for NIV can be presented at formal educational venues such as grand rounds and journal clubs. Technical training should ideally be one-on-one and hands-on. The hospital and departmental administration must appreciate that adequate personnel and equipment resources are necessary when implementing an NIV program. Guidelines and protocols may be useful as educational resources, to avoid clinical conflict, and to consolidate authority. When initiating an NIV program, it is important to recognize that NIV does not avoid intubation in all cases and that success often improves with experience. The available evidence suggests that NIV is cost-effective.

Limitations

There are several potential limitations of our study. We sent the survey to only 1 MD and 1 RT at each site, and thus assumed that their responses were reflective of the NIV utilization at the site. We did ask these individuals to solicit input from others if they were unsure of the appropriate response. We did not ask for the criteria to initiate NIV in the 132 EDs, although we speculate that it probably varied greatly from one ED to another. Another potential limitation is that we surveyed the use of NIV for only 3 diagnoses (asthma, COPD, CHF). However, it is unlikely that NIV is used commonly in the ED for other applications such as hypoxemic respiratory failure or postextubation. In our survey we did not ask for the number of patients requiring NIV, because that information is very difficult to correctly determine using a survey. Finally, we surveyed NIV use in academic EDs only and therefore cannot generalize to the use of NIV in other clinical settings.

Conclusions

Consistent with available evidence, NIV use is more common in the ED for acute COPD and CHF than for acute asthma. Barriers to greater use of NIV in the ED include physician familiarity, availability of an RT and equipment in the ED, and time required for NIV. For acute asthma, uncertainty about therapeutic benefits remains a challenge. Knowledge of these barriers should facilitate programs to increase the utilization of NIV in the ED for patients presenting with asthma, COPD, and CHF.
REFERENCES


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