Using Quality Indicators for Clinical Improvement

Presented to

South Carolina Hospital Association Members

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By
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Patient Safety Leader

Northwestern Memorial HealthCare
Objectives

1. Discuss the NMH process to manage clinical documentation for long-term benefit

2. Identify a tool / procedure to ensure accurate reporting of AHRQ Quality Indicators

3. Define a systematic approach to improve the safety of clinical care

4. Describe strategies to overcome common barriers to successful improvement
Northwestern Memorial Hospital
Chicago, Illinois

- 894-bed Academic Medical Center
- Primary Teaching Affiliate of Northwestern University Feinberg School of Medicine
- Magnet Recognition for Nursing Excellence
- Major Employer in City of Chicago
- One of five Healthcare Institutions in the U.S. with a AA+ Bond Rating
- Affiliated with Northwestern Lake Forest Hospital, a community hospital serving northern Illinois, in February 2010

Feinberg and Galter pavilions
Prentice Women’s Hospital
NMH Quality and Patient Safety Organizational Structure

VP, Quality & Operations

Director, Quality Strategies
- Infection Control (7.5)
- Patient Safety Leaders (3)
- Accreditation, Clinical Compliance
- Policy Coordinator
- Manager, Clinical Coding
- Coders (20)
- Clinical Quality Leaders (5)
- Manager, Clinical Documentation
- Clinical Documentation Specialists (4++)

Director, Quality Improvement
- Director, Process Improvement

Director, Process Improvement Leaders (6)
Framework for PSI Improvement

Goal: Understand issues, identify trends, determine opportunities, and inform the development of improvement strategies that will address the issues.

Clinical Documentation
Accurate reflection of the encounter?

Coding
Does it match documentation?

Clinical Practice
Was the event preventable?

After issues have been identified, develop and implement improvement strategies and monitor to sustain performance.
Patient Safety Indicator Monitoring Plan

• Oversight by Patient Safety Committee

• Patient Safety team monitors PSIs and facilitates further investigations
  o Individual PSI approach
    – Identify an owner (e.g., quality leader, DMAIC team, hospital committee)
    – Determine threshold level requiring investigation
    – Monitor PSI performance
      □ If PSI value rises above threshold:
        ▪ For 1 month/quarter, owner to conduct small sample review
        ▪ For 2 consecutive months/quarters, owner to review larger sample
    – Support owner as necessary with review and improvement follow-up
  o Present quarterly monitoring and/or review to Patient Safety Committee
<table>
<thead>
<tr>
<th>Patient Safety Indicator</th>
<th>Denominator</th>
<th>NMH Obs Rate/1000 D/C</th>
<th>AHRQ Target</th>
<th>UHC Obs Median</th>
<th>Current Initiatives/Owners</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHRQ Patient Safety Indicator Composite</td>
<td>--</td>
<td>0.86</td>
<td>1.09</td>
<td>0.89</td>
<td></td>
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<tr>
<td>PSI #2 – Death in Low Mortality DRGs</td>
<td>3,772</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>Mortality Rev</td>
</tr>
<tr>
<td>PSI #3 – Pressure Ulcer</td>
<td>2,454</td>
<td>1.6</td>
<td>--</td>
<td>0.7</td>
<td>Nursing Qual</td>
</tr>
<tr>
<td>PSI #4 – Death Among Surgical IPTs w Comp</td>
<td>139</td>
<td>115.1</td>
<td>119.3</td>
<td>134.2</td>
<td>Mortality Rev</td>
</tr>
<tr>
<td>PSI #5 – Foreign Body Left During Procedure</td>
<td>--</td>
<td>1.0</td>
<td>0.0</td>
<td>0.0</td>
<td>Pt Safety</td>
</tr>
<tr>
<td>PSI #6 – Iatrogenic Pneumothorax</td>
<td>7,940</td>
<td>0.3</td>
<td>0.4</td>
<td>0.5</td>
<td>Pt Safety</td>
</tr>
<tr>
<td>PSI #7 – Selected Infections Due to Med Care</td>
<td>7,441</td>
<td>0.0</td>
<td>0.7</td>
<td>0.3</td>
<td>DMAIC CLABSI</td>
</tr>
<tr>
<td>PSI #8 – Postop Hip Fracture</td>
<td>2,007</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>Surgical Oversight</td>
</tr>
<tr>
<td>PSI #9 – Postop Hemorrhage / Hematoma</td>
<td>3,135</td>
<td>5.4</td>
<td>3.3</td>
<td>3.5</td>
<td>FY09 DMAIC</td>
</tr>
<tr>
<td>PSI #10 – Postop Physiol &amp; Metabolic Derange</td>
<td>2,267</td>
<td>0.0</td>
<td>0.7</td>
<td>0.9</td>
<td>Pt Safety</td>
</tr>
<tr>
<td>PSI #11 – Postop Respiratory Failure</td>
<td>1,947</td>
<td>7.7</td>
<td>9.0</td>
<td>10.4</td>
<td>Pt Safety</td>
</tr>
<tr>
<td>PSI #12 – Postop DVT or PE</td>
<td>3,087</td>
<td>13.3</td>
<td>5.8</td>
<td>8.0</td>
<td>DMAIC DVT/PE</td>
</tr>
<tr>
<td>PSI #13 – Postop Sepsis</td>
<td>463</td>
<td>6.5</td>
<td>10.3</td>
<td>10.2</td>
<td>Infection Control</td>
</tr>
<tr>
<td>PSI #14 – Postop Wound Dehiscence</td>
<td>570</td>
<td>0.0</td>
<td>2.4</td>
<td>0.0</td>
<td>Surgical Oversight</td>
</tr>
<tr>
<td>PSI #15 – Accidental Puncture or Laceration</td>
<td>8,360</td>
<td>1.8</td>
<td>4.2</td>
<td>2.7</td>
<td>Coding</td>
</tr>
<tr>
<td>PSI #16 – Transfusion Reaction</td>
<td>--</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>Pt Safety</td>
</tr>
<tr>
<td>PSI #17 – Birth Trauma</td>
<td>2,960</td>
<td>1.7</td>
<td>2.2</td>
<td>2.9</td>
<td>OB Quality</td>
</tr>
<tr>
<td>PSI #18 – OB Trauma – Vaginal w Instrument</td>
<td>187</td>
<td>326.2</td>
<td>225.8</td>
<td>142.9</td>
<td>OB Quality</td>
</tr>
<tr>
<td>PSI #19 – OB Trauma – Vaginal wo Instrument</td>
<td>1,893</td>
<td>19.5</td>
<td>26.3</td>
<td>18.0</td>
<td>OB Quality</td>
</tr>
</tbody>
</table>

Green = O/E<1 & Better Than Median  Yellow = O/E>1 But Better Than Median  Red = Worse Than Median
Managing Clinical Documentation for Long-Term Benefit
Clinical Documentation

• Accurate reflection of the patient encounter: conditions treated, severity of illness, risk of mortality, DRG, ICD-9 coding, quality

• Specificity required for accurate coding, billing, and reporting

<table>
<thead>
<tr>
<th>MD documents…</th>
<th>Codes to…</th>
<th>SOI/ROM:</th>
<th>CC/MCC:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypoxemia</td>
<td>799.02 hypoxemia</td>
<td>1/1</td>
<td>-</td>
</tr>
<tr>
<td>Respiratory insufficiency</td>
<td>789.02 dyspnea &amp; respiratory abnormality</td>
<td>1/1</td>
<td>-</td>
</tr>
<tr>
<td>Respiratory distress</td>
<td>518.82 Other pulmonary insufficiency, not else classified</td>
<td>2/3</td>
<td>CC</td>
</tr>
<tr>
<td>Acute respiratory insufficiency</td>
<td>518.82 Other pulmonary insufficiency, not elsewhere classified</td>
<td>2/3</td>
<td>CC</td>
</tr>
<tr>
<td>Respiratory acidosis</td>
<td>276.2 Acidosis</td>
<td>3/2</td>
<td>CC</td>
</tr>
<tr>
<td>Chronic respiratory failure</td>
<td>518.83 Chronic respiratory failure</td>
<td>3/2</td>
<td>CC</td>
</tr>
<tr>
<td>Acute respiratory failure</td>
<td>518.81 Acute respiratory failure</td>
<td>4/4</td>
<td>MCC</td>
</tr>
</tbody>
</table>
Clinical Documentation at NMH

Model prior to June 2009
- Clinical documentation specialists reported to Case Management
- No clinician interaction other than electronic queries
- Room for improvement

![UHC Mortality Index for All Inpatients - Prior to Interventions June 2008 to June 2009](image)
Mortality Metrics Improvement Project

After analysis of the issues, improvements were implemented which focused on increasing the accuracy of documentation and coding.

100% Chart Review
- Ensure all appropriate codes are applied
- Identify opportunities for the V66.7 code (palliative care code)
- Identify opportunities for further clarification of documentation

Accurate Documentation and Coding
- New Clinical Documentation model to elicit physician cooperation with chart clarification
- Improved collaboration between Clinical Coding and Clinical Documentation

Improved Mortality O/E
- Improved Severity of Illness
- Improved Risk of Mortality
- Improved Mortality O/E
Current Clinical Documentation Model

New quality-focused approach
- Clinical Documentation Specialists now report to Director of Quality
- RELATIONSHIPS have been established - “structured rounding”
- Department expansion!

UHC Mortality Index for All Inpatients - Post Interventions
July 2009 to May 2011

- 1-Month Performance
- 3-Month Performance
- Goal
Quality Indicator Coding Procedure for Accuracy

AHRQ QI Toolkit Tip sheet!
Pre-Processed Coding Accuracy Procedure

**Problem:** How do we ensure PSI/HAC coding is accurate *before* it leaves the hospital’s control?

**Solution:** We validate the coding *before* it becomes a bill

• Charge recovery software (implemented September 2011)
  – Flags pre-processed bills for identified PSIs and Hospital Acquired Conditions (HACs)
  – Electronically routes chart/coding information to “owner” for timely chart review and coding validation
### Timely Chart Review

<table>
<thead>
<tr>
<th>Definition</th>
<th>Cases of iatrogenic pneumothorax per 1,000 discharges</th>
</tr>
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<tbody>
<tr>
<td>Numerator</td>
<td>Discharges with ICD-9-CM code of 512.1 in any secondary diagnosis field</td>
</tr>
<tr>
<td>Denominator</td>
<td>All medical and surgical discharges age 18 years and older defined by specific DRGs</td>
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</table>

Exclude cases with:
- ICD-9-CM code 512.1 in the principal diagnosis field
- MDC 14 (pregnancy, childbirth, and puerperium)
- ICD-9-CM diagnosis code of chest trauma or pleural effusion
- ICD-9-CM procedure code of diaphragmatic surgery repair
- any code indicating thoracic surgery or lung or pleural biopsy or assigned to cardiac surgery DRGs

### Collected Data Elements

- Presence of conditions represented by codes and PSI exclusionary conditions
- MD notes, test results related to the PSI complication
- Procedure details
  - Type, Location, Physician/Service, day of the week, time of day
- Patient factors
  - Reason for admission, age, Pulmonary comorbidity, Predisposing factors, POA
Algorithm for Pre-Bill Review

Flagged Account

Clinical Documentation
Oversight of case distribution; assist in process flow with goal of final determination within 4 days

PSI 15
Requests for Coding Review

PSIs: 5, 6, 10, 11, & 16
HACS: Foreign body, air embolism, blood incompatibility, poor glycemic control

PSIs: 2, 3, 4, & 12
HACS: Pressure ulcers, DVT/PE
Requests for Documentation Review

PSI 7
HACS: CAUTI, VCBSI, Mediast p-CABG, SSI post-ortho/bariatric surgery

Clinical Coding

Patient Safety

Clinical Documentation

Infection Control

Met Criteria?

Yes

No

Met Criteria?

Yes

No

Met Criteria?

Yes

No

Met Criteria?

Yes

No

Met Criteria?

Yes

No

Coding Accurate?

Yes

No

Assign Code

Fwd Clin Code

Coding Opportunity?

Yes

No

Documentation Opportunity?

Yes

No

Query MD

Chart Amended

Fwd Clin Doc

Fwd Clin Doc

Fwd Clin Doc

Fwd Clin Doc

Fwd Clin Doc

Documentation Opportunity?

Yes

No

No Response or Declined

Refer to Medical Dir for follow-up

Coding Opportunity?

Yes

No

Coding Opportunity?

Yes

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Documentation Opportunity?

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Release to Billing
Systematic Approach to Clinical Improvement

AHRQ QI Toolkit Tip sheets!
# The Adaptable AHRQ QI Prioritization Matrix

## UHC Partnership for Patients Prioritization Matrix

<table>
<thead>
<tr>
<th>Partnership for Patients Focus Areas</th>
<th>Section 1-Blue</th>
<th>Section 2-Green</th>
<th>Section 3-Purple</th>
<th>Section 4-Orange</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Rate per 1000 discharges *<em>count</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Own Rate and National Benchmark</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Media Year 2021</td>
<td>Calendar Year</td>
<td>Volume of Cases at Risk (CY2021)</td>
<td>Cost of Single Event</td>
<td>Total Cost</td>
</tr>
<tr>
<td>E</td>
<td>F</td>
<td>G</td>
<td>H</td>
<td>J</td>
</tr>
<tr>
<td>CMS 40% Reduction Goal</td>
<td>C</td>
<td>D</td>
<td>E</td>
<td>F</td>
</tr>
<tr>
<td>Own Rate and National Benchmark [Top Decile for Full UHC Members]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Volume of this event</td>
<td>Anticipated average cost for one case with this event</td>
<td>The total annual cost of this event to our organization</td>
<td>Anticipated cost to investigate/implement new process is less than annual cost of event</td>
<td>Strategic Alignment</td>
</tr>
<tr>
<td>P13 Pressure Ulcer**</td>
<td>0.79</td>
<td>1.33</td>
<td>0.22</td>
<td>3.9</td>
</tr>
<tr>
<td>Central Venous Catheter-Related Bloodstream Infections (CMS HAC measure)**</td>
<td>3.18</td>
<td>5.43</td>
<td>12</td>
<td>34</td>
</tr>
<tr>
<td>P12 VTE**</td>
<td>7.91</td>
<td>12.65</td>
<td>9.03</td>
<td>159</td>
</tr>
<tr>
<td>Obstetric</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P13 Obstetric Trauma-Vaginal Delivery With Instrument**</td>
<td>162.86</td>
<td>315.38</td>
<td>90.83</td>
<td>246</td>
</tr>
<tr>
<td>P13 Obstetric Trauma-Vaginal Delivery Without Instrument**</td>
<td>10.32</td>
<td>17.02</td>
<td>10.54</td>
<td>126</td>
</tr>
<tr>
<td>Readmissions 30 day all cause</td>
<td>13.50%</td>
<td>16.30%</td>
<td>11.03%</td>
<td>5278</td>
</tr>
</tbody>
</table>

**Toolkit Tip sheet & tool!**
DMAIC Process Improvement Methodology

DMAIC is a step by step methodology used to solve problems by identifying and addressing the root causes of a problem.

Define
- Identify the problem and goal

Measure
- Measure current performance

Analyze
- Validate key drivers of error

Improve
- Fix the drivers of poor performance

Control
- Use mechanisms to sustain improvement
Define
Pick Your Team

**Executive Sponsor**
Project responsibilities: provide overall guidance and accountability, remove barriers, provide strategic oversight and appropriate resources, review progress

**Sponsors**
Project responsibilities: accountable for success, responsible for implementation of recommendations, provide tactical oversight, reach clinical consensus

**Improvement Leader**
Project responsibilities: Accountable for using DMAIC to manage project and complete deliverables in a timely manner, partner with Process Owner

**Process Owner**
Project responsibilities: Accountable for implementing, controlling and measuring the project outputs and improvements

**Team Members:** Make significant and focused contributions to timely and successful implementation

**EVERYONE Is Involved and Accountable!**
• **Linkage to DEC/AMSK/DPCR:** DEC: Provide the highest quality, most effective and safest care.

• **Problem Statement:** Post-operative PE or DVT is an AHRQ safety measure. For 2009 Q2 (Apr-Jun) the NMH DVT/PE rate was 26.8/1000 with an AHRQ expected target of 6.0/1000. NMH’s rank is 102 out of 103 hospitals for Post-Op DVT/PE. After reviewing NMH’s post-op DVT/PE outcomes from Jan-June 2009, 50% of the outcomes were from Neurosurgery and Orthopedic patients.

• **Goal/Benefit:** Achieve and maintain an observed rate of Post-Surgical DVT/PE at or below 13/1000 while maintaining post-operative hemorrhage or hematoma rate at or below the target rate.

• **Scope:** Neurosurgery and Orthopedic inpatients

• **System Capabilities/Deliverables:** An improved process that will result in the reduction of the post-surgical DVT/PE rate.

• **Resources Required:** Clinical Quality, Surgical Services, Physician Leadership, Nursing, Neurosurgery, Orthopedics, PT/OT

### Key Metric(s):

- **Outcomes:**
  - Post Surgical DVT/PE rate
  - Post Surgical Major Bleed Rate

- **Process:**
  - Protocol Compliance

### Milestones:

2. Key Drivers Identified: 2/2010
3. Improvement Plan Approved: 3/2010

Executive Sponsor: C. Watts MD and S. Greene MD
Process Owner: TBD
Clinical Sponsors: T. Koski MD, K. Muro MD, L. Puri MD, and J. Weistroffer MD

Sponsor: R. Fortney and C. Payson
Improvement Leaders: J. Van Dyke and H. Shah MD

Toolkit Tip Sheet & Tool!
Measure & Analyze
Reducing DVT/PE – Measure

Problem: In Jan-June 2009, approximately 23.5 patients per 1000 cases experienced a post-operative DVT/PE complication at NMH.

Source: UHC Clinical Database
Reducing DVT/PE – Analyze

Drill into the data to find the issues that are key drivers of poor performance.

NMH Post Op DVT/PE Outcomes by Primary Procedure Physician’s Specialty (Jan-June 2009)

Total DVT/PE Cases

Source: UHC Clinical Database Outcomes, NMH Med Staff File for Primary Physician’s Specialty.
Reducing DVT/PE: Identify the Gaps Between Best Practice and Current Performance

VTE Prophylaxis Best Practices

1. Use of a universal VTE protocol
2. Chemoprophylaxis for all inpatients unless contraindicated
3. Mechanical prophylaxis as an adjunct to chemoprophylaxis or for patients with contraindications to chemoprophylaxis

The GAP: Why were NMH’s DVT/PE rates so high?
• Failure to use VTE prophylaxis appropriately on admission and throughout the inpatient stay
Improve
The Implementation Plan

Improvement Planning
To implement solutions successfully, five areas must be carefully considered and planned for:

1. Interventions
2. IT
3. Communication
4. Training
5. Measurement

Be sure to always include…
- Detailed actions
- Team member assignments
- Completion dates

50% of the work begins now

Toolkit
Tip sheet & tool!
Reducing DVT/PE: Improve

Implement strategies focused on the root causes of the problem.

<table>
<thead>
<tr>
<th>Component</th>
<th>Order Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dalkaparin</td>
<td></td>
</tr>
<tr>
<td>CBC</td>
<td>Routine, Once</td>
</tr>
<tr>
<td>For patients with CRCL &gt; 10 mL/min:</td>
<td></td>
</tr>
<tr>
<td>dalteparin (Fragmin)</td>
<td>5,000 Intl. Unit, Dose Form: Inj (Sub Q), Sub Q Injection, Daily (1 PM).</td>
</tr>
<tr>
<td>DVT Boot - Calf/Thigh</td>
<td>TID; On patient continuously</td>
</tr>
<tr>
<td>CBC</td>
<td>InAM, Mon’Wed Fri, T+1.0400</td>
</tr>
<tr>
<td>**</td>
<td></td>
</tr>
<tr>
<td>For patients with CRCL &lt; 10 mL/min see SubQ Heparin options.</td>
<td></td>
</tr>
<tr>
<td>SubQ Heparin</td>
<td></td>
</tr>
<tr>
<td>Order PTT and CBC with heparin</td>
<td></td>
</tr>
<tr>
<td>For patients &lt; 75 years of age &amp; CRCL &gt; 10 mL/min:</td>
<td></td>
</tr>
<tr>
<td>heparin</td>
<td>5,000 Unit, Dose Form: Inj (Sub Q), Sub Q Injection, TID, Start: T+1.0400</td>
</tr>
<tr>
<td>DVT Boot - Calf/Thigh</td>
<td>TID; On patient continuously</td>
</tr>
<tr>
<td>Partial Thromboplastin Time (PTT)</td>
<td>InAM, Mon Thurs, T+1.0400</td>
</tr>
<tr>
<td>CBC</td>
<td>InAM, Mon’Wed Fri, T+1.0400</td>
</tr>
<tr>
<td>**</td>
<td></td>
</tr>
<tr>
<td>For patients &gt; 75 years of age &amp; CRCL &gt; 10 mL/min:</td>
<td></td>
</tr>
<tr>
<td>heparin</td>
<td>5,000 Unit, Dose Form: Inj (Sub Q), Sub Q Injection, BID, Start: T+1.1200</td>
</tr>
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</tr>
<tr>
<td>For patients with CRCL &lt; 10 mL/min:</td>
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<tr>
<td>heparin</td>
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</tr>
</tbody>
</table>

History of Heparin Induced Thrombocytopenia or Heparin Allergy
Reducing DVT/PE: Improve

Partnering with Neurosurgery:
Neurosurgery modified their VTE prophylaxis protocols increasing their usage of chemoprophylaxis

New VTE Prophylaxis Protocol

- **Craniotomy**
  - Scan POD1
    - If stable, start SubQ Heparin TID
    - If not stable, Scan POD2 and possibly start SubQ Heparin TID
    - Mechanical Prophylaxis adjunct to chemoprophylaxis

- **Spine**
  - Start LMWH POD1 at 13:00
  - Mechanical Prophylaxis adjunct to chemoprophylaxis

Partnering with Orthopaedic surgeons:
Identified that the highest Post Op DVT/PE rates were in knee replacement patients

- **Chemoprophylaxis**
  - Many Joint surgeons have begun administering a half dose of LMWH on the night of surgery

- **Mechanical Prophylaxis**
  - Piloted increased mobilization on knee patients
  - Pilot used as basis for long term mobilization plan for all knee patients with a mix of physical therapy and nursing staff
Control
Reducing DVT/PE: Results

<table>
<thead>
<tr>
<th></th>
<th>Post Op VTE Rate</th>
<th>% Change</th>
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<tbody>
<tr>
<td>FY09</td>
<td>23.9</td>
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<tr>
<td>FY10</td>
<td>16.4</td>
<td>-31.4%</td>
</tr>
<tr>
<td>FY11</td>
<td>12.5</td>
<td>-23.7%</td>
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</table>

NMH Post Op DVT/PE Rate

<table>
<thead>
<tr>
<th></th>
<th>AHRQ DVT/PE Rate per 1000</th>
<th>UHC DVT/PE Rate per 1000</th>
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<tbody>
<tr>
<td>Q4</td>
<td>26.3</td>
<td></td>
</tr>
<tr>
<td>Q1</td>
<td>22.6</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>26.4</td>
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</tr>
<tr>
<td>Q3</td>
<td>24.8</td>
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<tr>
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<tr>
<td>Q1</td>
<td>14.2</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>11.2</td>
<td></td>
</tr>
</tbody>
</table>

When is a project “over”?

Sustainability
Overcoming Barriers to QI Success
Barrier: Lack of Resources and Time

‘Lack of Staffing’

‘Needed Resources Will Not Be Approved’

‘Not Enough Hours in the Day’

‘Quality Consists of One Person Here’

‘Task Saturation’
Strategies to Overcome A Lack of Resources and Time

1. Get Leadership Buy-In
   • Let them know why they should care: Patient Safety, Public Reporting, Financial Incentives

2. Spread the Work
   • Identify different owners for each QI

3. Fix the Easy Stuff First
   • Show improvement with the least amount of work and gain momentum along the way
Barrier: Resistance to Change

‘No Sense of Urgency’

‘No Buy-In’

‘People Don’t Like to Change’

‘Lack of Enthusiasm from Staff/Physicians’

‘Lack of New Ideas’
Strategies to Overcome Resistance to Change

1. Create A Shared Vision
   
   Northwestern Memorial is an academic medical center hospital *where the patient comes first*. We are an organization of caregivers who aspire to consistently high standards of quality, cost-effectiveness and patient satisfaction.

2. ALWAYS ALWAYS ALWAYS ALWAYS Involve Front-line Staff
   
   • A project without front-line staff input is destined to fail

3. Network
   
   • We Are All In This Together!
Helga Brake, PharmD, CPHQ
Patient Safety Leader
Northwestern Memorial Hospital
Chicago IL 60611
312.926.2034
hbrake@nmh.org

If you want to learn more about Northwestern Memorial Hospital, please visit our website at http://www.nmh.org

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