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VTE Collaborative Succeeding

35 hospitals enroll in first 18 months of mentoring, consultation program

by Kathleen Kerr



It has been nearly 18 months since SHM launched the VTE Prevention Collaborative, which offers individualized assistance to hospitalists wishing to take the lead on reducing the incidence of preventable, hospital-acquired VTE at their sites.

The collaborative features two technical assistance options: a full year of distance mentoring or a one-day evaluation and consultation visit to the enrollee's hospital. The project is led by Gregory Maynard, MD, and Jason Stein, MD. Both are stellar clinicians with quality improvement (QI) expertise and experience leading VTE prevention efforts. Dr. Maynard is head of the Division of Hospital Medicine and associate clinical professor of medicine at the University of California-San Diego. Dr. Stein is a hospitalist at Atlanta's Emory University Hospital, assistant professor of Medicine at Emory University School of Medicine, and director of Quality Improvement for the Emory Hospital Medicine Unit.

Though we expect to continue working with sites enrolled in the mentoring program for many more months, the collaborative has been in place long enough that we can start evaluating outcomes and thinking about what we've learned.

In all, 35 hospitals so far have enrolled in the collaborative: three in the consultation program and 32 in the mentoring program. Because the participants enrolled in the mentoring program generally were starting from an earlier point in the QI process (i.e., thinking about starting a project vs. trying to improve an existing effort), we've focused our evaluation attention on them.

At the time of enrollment, 33% of these sites were thinking of starting a VTE-prevention project, 42% had an active QI project but had not yet implemented any interventions, and 25% had an active QI project and had implemented an intervention (i.e., a new order set or risk-assessment protocol).

We surveyed the 21 sites that have been involved in the mentoring program for at least six months, asking about the status of their VTE-prevention project and their experiences working with SHM mentors. So far, 15 have responded to the survey, and the results are quite interesting.

Since becoming involved with the collaborative, nearly every participant had made significant progress with their project:

- 94% had redesigned the processes for assessing VTE risk and bleeding risk and providing appropriate prophylaxis;
- 100% had selected a VTE risk assessment model, and 88% had developed prophylaxis recommendations for each level of risk;
- 100% had defined absolute and relative contraindications to pharmacologic prophylaxis and recommendations for what to do if they exist;
- 100% had developed order sets or protocols that encourage initial assessment of VTE risk and provision of appropriate prophylaxis; and
- 75% had developed order sets or protocols in use at their hospitals.

All seven sites that had a baseline figure that could be used for comparison reported their current rate of appropriate VTE prophylaxis is higher than it was before they became involved in the collaborative.

We asked participants to identify the topics with which they were helped by their mentors. The responses showed the breadth of issues that need attention to create a successful QI project. The topics covered and percentage of enrollees who sought help with them include:

- Defining the goals, aims and scope of your project, 93%;
- Redesigning your VTE prevention process, 87%;
- Developing risk assessment and prophylaxis recommendations, 87%;
- Developing order sets and protocols, 87%;
- Data collection and measurement, 83%.

- Data collection and measurement, 57%;
- Piloting and revising risk assessment tools, order sets and protocols, 60%;
- Securing institutional support for your project, 47%;
- Assembling your project team, 47%;
- Mapping the original (pre-collaborative involvement) VTE prevention process at your site, 40%;
- Identifying and securing support from key stakeholders, 33%; and
- Developing educational/outreach strategies or materials, 27%.

Data collection and measurement remain a central issue for most participants. Nearly every mentoring call (mentors and participants speak once a month for the first six months of enrollment and every three months thereafter) focused at least in part on figuring out how to develop baseline data, monitor adherence to a new protocol, and determine if clinical outcomes were improving.

Of note, 100% of respondents said they would recommend the collaborative to others.

Hospitalists and QI

An impressive 67% of respondents indicated their work on the VTE project has helped identify them as a QI leader in their hospital or within their hospital medicine group. More impressively, 93% are working on or have signed up to work on other QI efforts.

The range of topics participants are turning their attention to are amazingly varied: acute coronary syndromes, heart failure, sepsis, glycemic control, pneumonia, delirium prevention, therapeutic hypothermia, hand washing, core measures, Joint Commission certification for a number of diagnoses/processes, do-not-resuscitate documentation/ordering, medication reconciliation, SCIP, hand-off communications, and computerized physician order entry. Or, as one respondent put it, “too many projects to name.”

While it is heartening that success in one area is being leveraged in other areas, a sobering reality is that only 7% of these folks have allotted time to pursue QI projects – all others do QI work on a volunteer basis, in addition to existing clinical and administrative responsibilities.

QI work is fun and rewarding but also time-consuming and at times, difficult and lonely. Heroic volunteerism is not necessarily a bad thing—many hospitalists are passionate about improving care and contributing to the hospitals where they work. Too much volunteerism leads to burnout and ultimately is not sustainable. Perhaps a mentoring emphasis should be helping people recognize and quantify the value of their efforts, and developing the negotiation skills that would help secure funding for their work.

What's Next?

Drs. Maynard and Stein are among the SHM members with an interest in VTE who have convened the VTE Advisory Board. Under the leadership of Sylvia McKean, MD, the advisory board is exploring ways SHM can continue its work to promote the prevention, diagnosis and treatment of VTE.

Areas of interest include working with health systems, as opposed to individual hospitals, as a means of rapidly spreading tools and processes that promote assessment of VTE risk and administration of appropriate prophylaxis. The VTE collaborative team was thrilled to welcome five Veterans Affairs (VA) hospitals into the collaborative. It is hoped this group will succeed not only in developing successful local VTE prevention efforts, but also will develop a framework and set of tools that can be exported to all VA sites. Leveraging commonly used health IT systems is another exciting option for rapidly disseminating the tools and materials the collaborative's members have developed.