

TIPS®

Topics in Patient Safety®



VA



U.S. Department of Veterans Affairs

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VA National Center for Patient Safety Topics in Patient Safety®

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TIPS® is published quarterly by the VA National Center for Patient Safety. As the official patient safety newsletter of the Department of Veterans Affairs, it is meant to be a source of patient safety information for all VA employees. Opinions of contributors are not necessarily those of the VA. Suggestions and articles are always welcome.

Thanks to all contributors and NCPS staff who offered their time and effort to review and comment on these TIPS® articles prior to publication.

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VA selects director for National Center for Patient Safety



William Gunnar, M.D., J.D., Executive Director, VA National Center for Patient Safety

The U.S. Department of Veterans Affairs (VA) is pleased to announce the appointment of Dr. William Gunnar as the executive director of the VA National Center for Patient Safety (NCPS) in Ann Arbor, Michigan.

“We are excited to bring Dr. Gunnar on board as the new executive director of the National Center for Patient Safety,” said Dr. Gerard Cox, VA deputy undersecretary of health for organizational excellence, who oversees NCPS. “His sound leadership qualities and proven experience as an educator, surgeon and VA national director of surgery will be valuable assets for NCPS staff, the greater VA patient safety community and, most importantly, the Veterans we are honored to serve.”

Dr. Gunnar transitions from his role as the national director of surgery for the Veterans Health Administration (VHA) where he’s served since November 2008. In this role, he provided leadership for the National Surgery Office and was responsible for the policy and clinical oversight of the 137 VHA

surgical programs, seventeen Surgical Advisory Boards and the Veterans Affairs Surgical Quality Improvement Program (VASQIP).

He graduated from Northwestern University with a combined Bachelor of Arts and Master of Science degree in 1979 and Northwestern University Medical School in 1983. He completed residency training in general surgery at the University of Illinois and Cook County Hospitals in 1989, and a fellowship in thoracic and cardiovascular surgery at Loyola University Stritch School of Medicine in 1991.

Following two years on the academic full-time staff at Loyola, he became principle in a private practice group in the Chicagoland area specializing in thoracic, cardiac and vascular surgery. He joined the faculty of the University of Chicago in 1997.

In 2002, he entered law school at Loyola University of Chicago School of Law, left private practice and soon thereafter joined the full-time staff at Hines VA Medical Center in Chicago. He completed law school in 2006, including a certificate in Health Law, and passed the Illinois Bar the same year while maintaining clinical, teaching, administrative and research responsibilities at Hines VA.

Dr. Gunnar has published in both fields of medicine and law and presented at numerous national and international meetings over the course of his career. He currently holds an academic appointment as clinical professor of surgery at George Washington University and is a Fellow of the American College of Surgeons and the American College of Healthcare Executives.

VA announces funding recipients for Patient Safety Centers of Inquiry



The U.S. Department of Veterans Affairs (VA) is pleased to announce the FY 2019 – FY 2021 Patient Safety Centers of Inquiry (PSCI) funding recipients. The VA National Center for Patient Safety (NCPS) administers the program and provides three years of funding for a PSCI to develop, disseminate and implement clinically relevant innovations that improve patient safety throughout VA.

Some past examples of PSCI initiatives include the creation of toolkits for falls and moderate sedation for non-anesthesiologists, protocols for reducing hospital-acquired infections, suicide prevention and a cancer care tracking system amongst many others.

“The Patient Safety Centers of Inquiry program is the pre-eminent patient safety innovation network in the Veterans Health Administration,” said VA Secretary Robert Wilkie. “Since 1999, the interventions implemented through the PSCI program have significantly contributed to our Veterans receiving the safest care anywhere.”

The following ten PSCI proposals were selected out of 36 applications in a highly competitive review process. The interdisciplinary PSCI review committee consisted of patient safety experts in-

cluding physicians, nurses, psychologists and pharmacists.

2019 – 2021 Patient Safety Centers of Inquiry (PSCIs)

VA Ann Arbor (Michigan) Healthcare System:

The general theme of the Ann Arbor Patient Safety Center of Inquiry (PSCI) is preventing healthcare-associated complications. The PSCI’s specific goal is to promote the appropriate use of two common medical devices among Veterans: urinary catheters and peripherally inserted central catheters (PICCs). Overuse of these devices can lead to both infectious and non-infectious complications. The PSCI will provide tools and approaches that promote appropriate urinary catheter and PICC use to reduce healthcare-associated complications within VHA.

James J. Peters VA Medical Center (Bronx, N.Y.):

The Center for Medication Safety in Aging is a Patient Safety Center of Inquiry (PSCI) located at the James J. Peters VA Medical Center. The goal of this center is to serve as a dissemination hub for efforts to reduce adverse medication effects in older adults and those with de-

mentia. The center hopes to consolidate the current state of knowledge about deprescribing best practices, engage VA innovators and facilities working in this area to form a network that shares practices and findings, and study implementation of these methods in VA settings.

Ralph H. Johnson VA Medical Center (Charleston, S.C.):

The Ralph H. Johnson VA Medical Center’s Patient Safety Center of Inquiry (PSCI) is dedicated to improving outcomes for Veterans transitioning between VA and non-VA care settings by specifically focusing on medication safety. The Charleston-based team plans to collect data to better understand the frequency and nature of Adverse Drug Events (ADEs) and potential ADEs among dual use Veterans. The PSCI further intends to develop a pharmacist-led medication safety program with initial deployment among high-risk community hospitalized Veterans and Veterans referred for specialty procedures in community settings. Finally, the PSCI will disseminate center-generated innovations within the VA Southeast Region (VISN 7) and nationally through partnerships with the VA Office of Community Care and the VA Pharmacy Benefits Management Service.

Michael E. DeBakey VA Medical Center (Houston, Texas):

The aim of the Houston VA’s Diagnosis Improvement Safety Center (DISCOVERY) is to prevent diagnostic errors (which affect 5 percent of US adults every year) by improving timely follow-up of abnormal test results. Failure to follow-up on abnormal test results in a timely manner is a major factor contributing to diagnostic errors. The PSCI is working with clinicians and hospital leadership to develop and test a system to measure missed follow-up of abnormal test results. The system will provide clinicians and leadership feedback about these missed results, thereby enabling learning and improvement of subsequent test result follow-up and safer diagnosis.

Iowa City VA Health Care System:

The goal of the Center for Antimicrobial Stewardship and Prevention of Antimicrobial Resistance (CASPAR) is to develop and test automated risk-adjusted metrics for antimicrobial stewardship programs (ASPs) that are adaptable to the diverse care settings across VHA. The CASPAR objectives are: 1) to develop evaluation tools for ASPs and the Multi-drug Resistant Organisms (MDRO) prevention program that are adaptable to the diverse nature of care settings among VHA facilities, and 2) to develop an outcome tracking system for the ASP and MDRO prevention program utilizing information technologies.

VA Greater Los Angeles Healthcare System:

The VA Greater Los Angeles Healthcare System Patient Safety Center of Inquiry (PSCI) is planning to focus on transitions of care for complex Veterans, particularly elderly Veterans, with their transitions in and out of the hospital for surgical procedures and for medical conditions. In addition to transitions/handoffs (in and out of hospital), specific processes will be tested to look at impact on other designated areas of patient safety focus as well as impact on 30-day readmission and patient-centeredness/satisfaction. The goal is to test the transition-specific tools and processes in reduction of adverse events/targeted patient safety areas with subsequent dissemination to other sites.

VA Puget Sound Health Care System:

The VA Puget Sound Health Care System's Supporting Primary Care Providers in Opioid Risk reduction and Treatment (SUPPORT) Patient Safety Center of Inquiry (PSCI) works with primary care providers to identify patients at high risk for adverse opioid-related outcomes and monitor patient opioid use and outcomes. Additionally, the PSCI provides guidance regarding tapering opioid prescriptions, and connecting patients with opioid use disorder with evidence-based pharmacotherapies to treat opioid use disorder in the primary care setting. The project also involves the creation of a

database to track patients' opioid doses, outcomes, contact with the team, and standardized note templates to facilitate assessment and pharmacologic treatment of opioid use disorder.

James A. Haley Veterans Hospital (Tampa, Fla):

The Patient Safety Center of Inquiry (PSCI) at the James A. Haley Veterans Hospital is dedicated to preventing adverse events related to mobility/immobility focusing on prevention of injurious falls, safe patient handling/mobility (SPHM) and pressure ulcer prevention. The PSCI examines best practices in fall and injury prevention, issues surrounding assisted falls, development of virtual simulation training for staff fall prevention education, evaluation of evidence on pressure ulcers and injury risk related to lift device slings and/or air transfer devices. Ongoing PSCI projects include the Falls Toolkit for Home Based Primary Care, evaluation of stand-bars for power wheelchair users, evaluation of novel compliant flooring for fall injury prevention and innovative applications of SPHM technology in rehabilitation.

Doris Miller VA Medical Center (Waco, Texas):

The overarching mission of the Patient Safety Center of Inquiry-VA Suicide Prevention Collaborative (PSCI-VASPC) is to develop, implement, and evaluate practical solutions to reduce suicide among Veterans who are not receiving VA care. The PSCI-VASPC has three specific objectives: 1) the PSCI-VASPC seeks to develop a collaborative organizational structure that connects VA and community suicide prevention services, 2) the center will share suicide prevention best practices between VA and the community to increase access for all Veterans, and 3) the PSCI-VASPC will develop a new program of effective, low-cost suicide prevention services for Veterans with emergent mental health needs that will capitalize on best practices for suicide prevention in VA and the community. The center will create products to support the spread of these practices to other VA medical centers and work to ensure these programs are sustainable. The PSCI-VASPC

will serve as a national clinical innovation and dissemination center for best practices in suicide prevention for Veterans who receive care in the community.

White River Junction (Vermont) VA Medical Center:

The White River Junction VA Patient Safety Center of Inquiry's (PSCI) goal is to adapt and pilot an evidence-based program to decrease suicide risk following psychiatric discharge in the VA treatment population. The PSCI also aims to identify additional high-risk VA patients who comprise clinically coherent groups that may be additional target populations for this intervention.

Putting a Face to a Name: Your Patient Safety Team

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Documented secondary assessment decreases preventable VTE outcomes

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Background:

Venous thromboembolism (VTE) continues to be a major cause of morbidity and mortality with approximately 100,000 confirmed deaths annually in the United States.¹ Efforts to improve the implementation gap for VTE prophylaxis guidelines into practice have been ongoing for decades. In 2008, the VA Office of Inspector General (OIG) evaluated adherence to evidence-based recommendations for prevention of VTE in hospitalized patients. The Prevention of VTE in VA Hospitals Report (06-02459-209) estimated that only 63% of at-risk patients received appropriate VTE prophylaxis.

The OIG recommends all VA facilities to develop and implement a plan to ensure appropriate VTE preventative therapies for at-risk hospitalized patients. In 2014, the VA OIG investigated potentially preventable pulmonary embolisms (PE) at 29 VHA medical facilities. The Preventable PE at VA Facilities Report (14-01073-139) revealed that 15% of 259 confirmed PEs with at least one PE risk factor had missed or delayed PE diagnosis or inadequate prophylaxis.

The Veterans Healthcare System of the Ozarks (VHSO) initially adopted a VTE prevention program in 2009 utilizing a "Three Bucket" model to stratify patients into low, moderate, or high risk groups based on known VTE risk factors.² Providers were required to evaluate hospitalized patients via computerized checklist within 24 hours of admission or transfer.

In 2013, a VTE related adverse event at the facility led to a Root Cause Analysis. A multidisciplinary task force was challenged with creating a strategy to augment existing VTE prevention efforts. They found that the inpatient clinical pharmacist was in a unique position to evaluate admitted patients for appropriate pharmacologic prophylaxis.

Methods:

A new CPRS note title and template were developed: Pharmacy Review VTE Prophylaxis (Figure 1). The template has

Figure 1. Pharmacist selection screen in the computerized medical record.

four selections: 1) low risk, 2) prophylaxis ordered, 3) prophylaxis indicated, and 4) pharmacologic prophylaxis contraindicated. The selection options had pre-filled text that could be modified, if needed. If option three (prophylaxis indicated) was selected, the patient's provider was added to the note for co-signature. These notes were stored in the progress notes of the patient's permanent medical record. The VTE prevention effort was further enhanced with reminders of VTE prophylaxis embedded in the nursing shift assessment.

The novel note and template went into effect in January 2014. All hospitalized patients should have the assessment and note completed in CPRS within 48 hours of admission. The facility set a benchmark of 90% for this quality initiative.

Results:

Inpatient VTE complications were later compared in before and after cohorts. Over 36,000 discharges were reviewed between 2008 to 2018 for incidence of VTE events before and after the 2014 pharmacy intervention. Aggregate data from VA's Strategic Analytics for Improvement and Learning (SAIL) were reviewed for inpatient VTE events and 30-day readmissions for VTE. The augmented assessment strategy led to a decrease in both inpatient VTE (0.20% to 0.11%), and 30-day readmissions for VTE (0.16% to 0.04%).

Rates of appropriate prophylaxis were studied after the 2014 intervention through VA Inpatient Evaluation Center (IPEC) monitoring. The combined phar-

macologic prophylaxis rate was 86% with 92% present in high-risk ICU patients and 81% in acute care patients.

Discussion:

VTE reduction strategies should be multi-faceted for best outcomes, such as electronic decision support which is supplemented with prospective audit and feedback. VTE risk factors should be assessed frequently during an inpatient stay because a change in a patient's VTE risk level is credited with 20% of failures with traditional methods. Additionally, physician-focused VTE programs that are overly complicated may be bypassed.³

The inpatient pharmacist reported that the new process was easily incorporated into daily workflow, with an added benefit of providing a CPRS note for encounter capture and documenting interventions in PhARMD Tool. Feedback from the medical service was that the secondary assessment was helpful in catching overlooked or forgotten pharmacologic orders.

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